FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47 — 27982
Primary Registration District No. ....
(No. ...., ... St.)
File No. 73
Registered No. 2124
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lewis
City of Nezperce
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sophie Gibson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 14 (Day) 1920 (Year)

7. AGE: 19 Yrs. .... Mos. 9 .... ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: John Wilke

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Mary Edmonson

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. P. Gibson
(Address) Fraitville Ark

15. Filed 1-20 1920 Albert Hoff Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1920 to Jan 15 1920
that I last saw h alive on Jan 15 1920.
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH*, was as follows:
Peritonitis
(Duration) .... Yrs. .... mos. 10 ds.
Contributory (Secondary) Lupus Sepsis
(Duration) .... Yrs. .... mos. 5 ds.
(Signed) John T. Gist M. D.
19.... (Address) Nezperce Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Fraitville Ark. DATE OF BURIAL: .... 191...

20. UNDERTAKER: Albert Hoff ADDRESS: Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2016
File No. 28038
Registered No. 1

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Lucille Malcolm

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 7 (Day) 1895 (Year)

7. AGE: 24 Yrs. 6 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. M. Snell

11. BIRTHPLACE OF FATHER (State or Country): Spanish Fork, Utah

12. MAIDEN NAME OF MOTHER: Annie Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Spanish Fork, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E E Snell
(Address) 779 Wash. Ogden

15. Filed Jan. 6 1920 J. L. Turner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1920, to Jan 5 1920, that I last saw h[er] alive on Jan 5 1920 and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Acute cardiac Dilatation
(Duration) ..... Yrs. Suddenly mos. ..... ds.
Contributory (Secondary) Anaethenia
(Duration ..... yrs. few minutes mos. ..... ds.
(Signed) ..... M. D.
Jan 6 1920 (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. [illegible] mos. 5 days. In the State 16 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Carey Ida.
Former or usual residence Carey Idaho

19. PLACE OF BURIAL OR REMOVAL: Carey Idaho
DATE OF BURIAL 191

20. UNDERTAKER: O L Brennan
ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. County Hospital)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122
Primary Registration District No. 2200

File No. 28047
Registered No. 16
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward O'Brein

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE: 67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ireland
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph F Bohlman
(Address) Wallace, Idaho
15. Filed Jan 6 1920 H. C. Moorey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 4 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 1/15/19 191..., to Jan 4 1920, that I last saw him alive on Jan 3 1920, and that death occured on the date stated above, at 7:20 P.M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Arteriosclerosis
(Duration 4 years yrs. ..... mos. ..... ds.
1/6/20 (Signed) James R Brain M. D.
(Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill — DATE OF BURIAL: 1/7 1920
20. UNDERTAKER: E. E. Norcutt — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKB. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28156
Registered No. 1679

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls
(No. Spencer Hosp. St.)
Registration District No. 73
Primary Registration District No. 2104

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva S. Burton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Apr 8 1890 (Month) (Day) (Year)

7. AGE: 29 Yrs. 8 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charles V. D. Shurtleff

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Alzina Smith

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. V. Shurtleff Jr.
(Address) Lewisville, Ida.

15. Filed Jan 6 1920 Wm Hammond Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 26 1919 to Jan 2 1920 that I last saw h[er] alive on Jan 2 1920 and that death occurred on the date stated above, at 7-30 P.M.

The CAUSE OF DEATH* was as follows:
Meningitis following a pelvic Injection
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pregnancy
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. Hartman M. D.
1/5 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewisville | DATE OF BURIAL: 1/6 1920

20. UNDERTAKER: C. E. Linwoodley | ADDRESS: Idaho Falls

Dr Spencer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6034

Registered No. .....

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 915 Hays. St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred A. Little

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Married (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 4 (Day) 1870 (Year)

7. AGE: 49 Yrs. 0 Mos. 27 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Civil engineer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Lucien Little

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Sylvia Coukey

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice M. Little
(Address) 95 16 Garfield Ave

15. Filed Jan 14th 1920 L. P. Pearce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 27 1919, to Jan 1 1920 that I last saw h-im alive on Jan 1 1920 and that death occurred on the date stated above, at 6 40 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular heart
Fatty over dil. Dilated

One (Duration) / Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) / ..... yrs. ..... mos. ..... ds.

(Signed) Geo. King Bovey M. D.
Jan 1920 (Address) 404 Idaho Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cleveland Ohio	Jan 1 1920

20. UNDERTAKER: Fry, Summers & Kirk ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6335

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Kroystantin Resiotis (Gust Rice) St.)

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 1886 (Month) (Day) (Year)

7. AGE: 32 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Trackman

(b) General nature of industry, business or establishment in which employed (or employer): B.P.Co Gabarton, Ida

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: George Resiotis

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Katherine argyropoulos

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) W. K. Alexander

15. Filed Jan 6th 1920 L. P. Eisman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23rd 1919 to Jan 2nd 1920 that I last saw h.i.m. alive on Jan 2 1920, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas & Duodenum

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. McCallum M. D.

1/3 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence near Cascade Valley Co.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	1/8 1920
20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Amended items #16, 17, & 19 6-8-94 ms

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28336

Registered No. 4

1. PLACE OF DEATH

County of Ada

City of Boise (No. Mitchell Hotel St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah N. Holloway.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec 10 (Month) (Day) 1845 (Year)

7. AGE: 74 Yrs. — Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Lewis Mulford.

11. BIRTHPLACE OF FATHER (State or Country): New Jersey.

12. MAIDEN NAME OF MOTHER: Amy Miller.

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie Holloway

(Address) Boise, Ida.

15. Filed Jan 7 1920

L. P. Truman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 5 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1919 to Jan 3 1920 that I last saw her alive on Dec 31 1919 and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. J. Smith M. D.

1/6 1920 (Address) Mrs. J. Conway Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Jan 7 1920

20. UNDERTAKER: Summers & Webb

ADDRESS: Boise Idaho.

IDAHO DEPARTMENT OF HEALTH AND WELFARE 4-22-92
Cooperative Center for Health Statistics
Vital Statistics Unit

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

RECEIVED
BUREAU OF
VITAL STATISTICS
MAY 23 10 39 AM '94

State of Idaho
County of Ada } ss.

Certificate No. 28336
Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death
for Sarah H Holloway (Name on Original Certificate) who died (Was Born, Died, etc.) on Jan 5, 1919 (Date of Event)
in Boise (Ada) (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
Date of death	Jan 5, 1919	Jan 5, 1920
Date last seen alive	Dec 31, 1920	Dec 31, 1919
Date of burial	Jan 7, 1929	Jan 7, 1920

Subscribed and sworn to before me this 13th day of May, 1994.
X Notary Public, Anita Bernard Clifton
Residing at Fresno California
My commission expires 2/20/98

ANITA BERNARD CLIFTON
COMM. #1000969
NOTARY PUBLIC-CALIFORNIA
PRINCIPAL OFFICE IN
FRESNO COUNTY
My Commission Exp. Feb. 20 1998

X Mary Ellen Holloway White
Signature of Applicant
X 3683 W. Fedora Fresno
Street Address, City, State Ca. 93722

SUPPORTING AFFIDAVIT OF A SECOND PERSON

(Must be completed ___)
(Is not necessary ✓)

State of
County of ___ } ss.

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this ___ day of ___, 19___.
Notary Public, ___
Residing at ___
My commission expires ___
(Seal)

Supporting Signature

Street Address, City, State

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28557
Registered No. 5

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 409 Main St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles F. Coffman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH: Aug. (Month) 17 (Day) 1870 (Year)

7. AGE: 49 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Street Car Employee

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John W. Coffman

11. BIRTHPLACE OF FATHER (State or Country): Ann.

12. MAIDEN NAME OF MOTHER: Eunice A. Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Kayll F. Coffman

(Address) 409 Main Street.

15. Filed 2/6 1920

L. E. Forman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1919 to Jan 6 1920

that I last saw him alive on Jan 6 1920

and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(Duration) 3 yrs. 6 mos. — ds.

Contributory (Secondary) Toxic Argyrotism

(Duration) 3 yrs. 5 mos. — ds.

(Signed) H. Pond M. D.

1-7 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/8 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Boise

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 20338
Registered No. 16

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 604 East Jefferson St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma M. La Francois

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Nov. 29 1866 (Month) (Day) (Year)

7. AGE: 53 Yrs. 1 Mos. 8 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Etienne Robidge

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eva La Francois Corbett

(Address) Salt Lake City

15. Filed 1/6 1920 L. B. Herman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 6th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1920, to Jan. 6 1920 that I last saw h.. alive on Jan 5 1920, and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Earl Hill M. D.

1/6 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..yrs..mos..days. In the State ..yrs..mos..days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 1/8 1920

20. UNDERTAKER: Schreiber & Redemptorden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Bill Hill

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28339
Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Michigan & Beacon St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel R. Peerman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 27 (Day) 1863 (Year)

7. AGE: 56 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lumber Grader

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Peerman

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ivay Peerman

(Address) 711 Michigan St Boise

15. Filed Jan 8 1920 L. P. Pfirman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Dec~~ Jan. 6th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1919, to Dec 6 1919, that I last saw h.. alive on Dec 6 1919, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows: Acute Uraemic Poisoning

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R E Sturtz M. D.

1/7 1920 (Address) Overland Bld

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Do Boise Ada

19. PLACE OF BURIAL OR REMOVAL: Harris Hill Cemetery — DATE OF BURIAL: 1/9 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

Stuntz

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28510
Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 1703 N. 13th St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John M. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Mar 7th 1854 (Month) (Day) (Year)

7. AGE: 65 Yrs. 10 Mos. 1 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Wm Jones.

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Hester A Alley

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Alice Whelan

(Address) Boise

15. Filed Jan 9 1920 L. O. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 8th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1919 to Jan 8 1920 that I last saw h-m alive on Jan 1 1920 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

arterio sclerosis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary) Myocardial degeneration

(Duration) 2 yrs. mos. ds.

(Signed) W. H Dellman M. D.

1-9 1920 (Address) Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Klickatat Co Wash

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery DATE OF BURIAL: 1/10 1920

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise

D. A. Tallman

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2341

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410 State St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emily J. Borgeson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Nov. (Month) 20 (Day) 1846 (Year)

7. AGE: 73 Yrs. 1 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Mr Wilson

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. Borgeson
(Address) Boise R.D. #4

15. Filed Jan 10 1920 L. C. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1919, to Jan 9 1920, that I last saw her alive on Jan 9 1920, and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) none

(Duration) yrs. mos. ds.

(Signed) J W Cannon M. D.

19 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence none Franklin Idaho ada Co

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/13 1920

20. UNDERTAKER: Schreiber & Hidenfeden — ADDRESS: Boise

Cannon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 20912
Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 410 State St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Mc Nish Bradley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 13th (Day) 1900 (Year)

7. AGE: 19 Yrs. 5 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Employed at

(b) General nature of industry, business or establishment in which employed (or employer): Statesman

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: David C. Bradley

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mary Mc Nish

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Bradley

(Address) So. Boise

15. Filed Jan 10 1920 L. R. Hansen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1919 to Jan 9 1920 that I last saw h. in alive on Jan 9 1920 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Surgical Shock

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Peritonitis from Gall Bladder & Appendix

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Tatsuda M. D.

1/10 1920 (Address) Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Weiser Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/13 1920

20. UNDERTAKER: Schrader & Eidemfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. Pittinger

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28343

Registered No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1214, Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Pauline Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Jan 31st 1836 (Month) (Day) (Year)

7. AGE: 84 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Columbus Ohio

10. NAME OF FATHER: Foundry Taylor

11. BIRTHPLACE OF FATHER (State or Country): U.S.A

12. MAIDEN NAME OF MOTHER: Miss Wickem

13. BIRTHPLACE OF MOTHER (State or Country): U. S. A

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. K. Davis

(Address) 1016 Franklin St

15. Filed Jan 10 1920 L. P. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1920 to Jan 3 1920 that I last saw h[illegible] alive on Jan 3 1920 and that death occurred on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm F. Smith M. D.

1/10 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 1/12 1920

20. UNDERTAKER: Schmitt & Hidenfeldt — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28344
Registered No. 17

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert A Mahany.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
M.	White	Married

6. DATE OF BIRTH: Sept (Month) 7 (Day) 1861 (Year)

7. AGE: 58 Yrs. 4 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Book-keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Brunswick.

10. NAME OF FATHER: Robert Mahany.

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Robert Mahany.
(Address)

15. Filed Jan 16 1920 L. P. Gunman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1919, to Jan 13 1920, that I last saw him alive on Jan 12 1920, and that death occurred on the date stated above, at 10a. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 15 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J Mahany M. D.
Jan 14 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Jan 15 1920

20. UNDERTAKER: Summers & Kerns — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28245
Registered No.

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. St Lukes Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herman M. Pure.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): S

6. DATE OF BIRTH: — (Month) — (Day) 1860 (Year)

7. AGE: 60 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Webb.
(Address) Boise Idaho

15. Filed Jan 17 1920 L. O. Summers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 15 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920 to Jan 15 1920 that I last saw him alive on Jan 15 1920 and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Barth M. D.
Jan 17 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Jan 17 1920

20. UNDERTAKER: Summers & Webb. — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Parker

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28346

Registered No.

1. PLACE OF DEATH

County of Ada.

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 110 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lora E. Harrell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 29 (Month) (Day) 1901 (Year)

7. AGE: 18 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Harrell.

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Martha Childers.

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. Harrell

(Address) Camfridge Idaho.

15. Filed 1/18 1920

L O Foreman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1920, to Jan 18 1920

that I last saw her alive on Jan 18 1920

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O H Parker M. D.

19 (Address) 303 McCarty Blk

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Camfridge Idaho DATE OF BURIAL: Jan 20 1920

20. UNDERTAKER: Summers & Scobs ADDRESS: Boise Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 20347
Registered No. 16

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1305 E. Jefferson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Columbus Lincoln Sandborn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 12 (Day) 1896 (Year)

7. AGE: 23 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Office Clerk
(b) General nature of industry, business or establishment in which employed (or employer): //

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: J. W. Sandborn

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Alma Fuscher

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Riley Sandborn
(Address) Portland Michigan

15. Filed Jan 19 1920 L. O. Brunes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ Jan 18 1920 to ..... 19..... that I last saw h~~im~~ alive on ..... 19..... and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

..... (Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Brunner Coroner M. D.
1/19 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portland Mich. DATE OF BURIAL: Jan 25 1920

20. UNDERTAKER: Brunner & Krebs ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Parker.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 134

(No. 1320 W. Jefferson St.)

File No. 2348

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Frances Tingley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH: Aug. (Month) 7 (Day) 1917 (Year)

7. AGE: 2 Yrs. 5 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. L. Tingley

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Jessie Hoult

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nelle Hoult
(Address) American Falls, Idaho

15. Filed Jan. 22 1920 L. P. Perryman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18 1920, to Jan 20 1920, that I last saw h.r alive on Jan 20 1920, and that death occurred on the date stated above, at 10a M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Flu
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C H Parker M. D.
19..... (Address) 203 Mc Carty

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Jan 22 1920

20. UNDERTAKER: Summers & Keeler — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Hawley.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 28349
Registered No. 18

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 431 So 11 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Philip Thomas Worthington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Never Married)

6. DATE OF BIRTH: June (Month) 12 (Day) 1907 (Year)

7. AGE: 12 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Samuel W. Worthington

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Margaret C. Borup.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas P. & P. Borups
(Address) 519 So 16th.

15. Filed 1-23-20 19 L. P. Pfirman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 18 1919, to Jan 21st 1920 that I last saw him alive on Jan 21st 1920, and that death occurred on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:
Chronic dilation of heart + final failure
(Duration) 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bronchitis + Rheumatism
(Duration) 4 yrs ..... mos. ..... ds.

(Signed) Geo. H. Hawley M. D.
Jan 23 1920 (Address) 916 State St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 12 mos. ..... days. In the State 14 yrs ..... mos. ..... days
Where was disease contracted if not at place of death? Kansas Prairie
Former or usual residence Kansas Prairie

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. — DATE OF BURIAL: Jan 25 1920.

20. UNDERTAKER: Summers & Webb. — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Shasta

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28350

Registered No. 29

1. **PLACE OF DEATH**

County of Ada

City of Boise

Registration District No.

Primary Registration District No. 1004

(No. Manitou Hotel St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Bertha B Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: F

4. **COLOR OR RACE**: W

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Married

6. **DATE OF BIRTH**: Mch 6 1887 (Month) (Day) (Year)

7. **AGE**: 32 Yrs. 10 Mos. 16 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): —

9. **BIRTHPLACE** (State or Country): Kansas

10. **NAME OF FATHER**: Walsh Tyler

11. **BIRTHPLACE OF FATHER** (State or Country): Missouri

12. **MAIDEN NAME OF MOTHER**: Carrie Bryant

13. **BIRTHPLACE OF MOTHER** (State or Country): Georgia

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs Myrtle Hickey

(Address) R-4 Caldwell

15. Filed 1-23-20 19..... L P Pfirman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Jan 22 1920. (Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan 15 1920 to Jan 22 1920 that I last saw h.dr alive on Jan 22 1920 and that death occurred on the date stated above, at 7:40 M.

The **CAUSE OF DEATH*** was as follows:

Pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. 10 ds.

(Signed) R. E. Shuntz M. D.

1/23 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Morris Hill Cem. **DATE OF BURIAL**: Jan 23 1920.

20. **UNDERTAKER**: Summers Bros. **ADDRESS**: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28351
Registered No.

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1203 Franklin St.)
Registration District No.
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dora Strauss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: W (~~Write the word.~~)

6. DATE OF BIRTH: (Month) (Day) 1840 (Year)

7. AGE: 80 Yrs. 0 Mos. 6 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Austria.

10. NAME OF FATHER: Joseph Nadler.

11. BIRTHPLACE OF FATHER (State or Country): Austria.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Austria.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed Strauss
(Address) 1205 Franklin

15. Filed 1-23-20 L. P. Pfarrer, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to Jan 21 1920, that I last saw h~~e~~r alive on Jan 21 1920, and that death occurred on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:
Uremic Toxicity
Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James L. [illegible] M. D.
1/21/1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Jan 23 1920

20. UNDERTAKER: Summers & Hebo. — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28352

Registered No.

1. PLACE OF DEATH

County of Ada.

City of Boise

(No. 614 N. 16th St.)

Registration District No.

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Rigdon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 25 (Day) 1902 (Year)

7. AGE: 17 Yrs. 9 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: William Rigdon

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Myrtle Bailey,

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Myrtle Bailey, McB.

(Address) Boise Idaho.

15. Filed Jan. 24 1920 L. P. Pfarman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan ~~25~~ 19 1920, to Jan 22 1920, that I last saw him alive on Jan 21 1920, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Influenza.

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) T. N. Brattan M. D.

1/27 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/24 1920

20. UNDERTAKER: W. McBratney — ADDRESS: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28353

Registered No.

1. PLACE OF DEATH

County of Ada.

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 1602 Harrison Blvd. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. H. Leitner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH July 31 — 1847.
(Month) (Day) (Year)

7. AGE 72 Yrs. 5 Mos. 21 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): Post Master.

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Paul Leitner

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Shoemacher

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise. Idaho.

15. Filed 1-24 1920 L P Pfirman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 6 1920, to Jan 2 2 1920, that I last saw h[illegible] alive on Jan 2 2 1920, and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage Caused by fall on ice at [illegible] 1

(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) W. R. Nunn M. D.

1/23 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Baker - Oregon	1/25 1920

20. UNDERTAKER	ADDRESS
W McBratney	Boise, Idaho,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

Shurtz

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
File No. 23354
Registered No. 23

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1712 No 7th St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Tinsley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (write the word.)

6. DATE OF BIRTH: Aug 22 1839 (Month) (Day) (Year)

7. AGE: 80 Yrs. 4 Mos. 29 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): ----------

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Seddon

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Bullough

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard Tinsley

(Address) 1712 N 7 st B

15. Filed 1-24 1920 L. P. Plummer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 21 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to Jan 21 1920 that I last saw h dr alive on Jan 21 1920 and that death occurred on the date stated above, at 1- P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) R E Shurtz M. D.

Jan 24 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill cemetery DATE OF BURIAL: Jan 24 1920

20. UNDERTAKER: Summers & Krebs ADDRESS: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. ____
File No. 20355
Registered No. ____

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Mabel Sloan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 1 (Day) 1877 (Year)

7. AGE: 42 Yrs. 9 Mos. 22 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework.
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Del.

10. NAME OF FATHER: Thomas J. Hervey

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Mary Hambridge

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Sloan
(Address) Parma Ida

15. Filed 1-24 1920 L. P. Pfirman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-17-1920 to Jan 23 1920
that I last saw h.er alive on Jan. 23 1920
and that death occurred on the date stated above, at 11A. M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
Pulmonary -
(Duration) 15 Yrs. ____ mos. ____ ds.
Contributory (Secondary) ____
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) R. E. Cluer M. D.
1-24 1920 (Address) Parma, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Parma Idaho | DATE OF BURIAL: Jan 25 1920
20. UNDERTAKER: Summers & Kreps | ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. .....

Primary Registration District No. .....

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25356

Registered No. .....

1. **PLACE OF DEATH**

County of Ada

City of Boise

(No. Market & Fort St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Helen Augusta Clutter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. **DATE OF BIRTH** July (Month) 13 (Day) 1853 (Year)

7. **AGE** 66 Yrs. 6 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. **BIRTHPLACE** (State or Country) Ill.

10. **NAME OF FATHER** T. A. Rogers

11. **BIRTHPLACE OF FATHER** (State or Country) Unknown

12. **MAIDEN NAME OF MOTHER** Susan Curtis

13. **BIRTHPLACE OF MOTHER** (State or Country) Unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) C. C. Clutter

(Address) Los Angeles Calif.

15. Filed 1-24-20 L. P. Pfarman, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Jan (Month) 22 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan 21 1920, to Jan 22 1920 that I last saw h.e alive on Jan 22 1920, and that death occurred on the date stated above, at 11:45 P.M.

The **CAUSE OF DEATH*** was as follows:

Influenzal Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Chr. Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. B. Burke M. D.

1/24 1920 (Address) 410 Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Washington Iowa | **DATE OF BURIAL** Jan 27 1920

20. **UNDERTAKER** Summers-Kirk | **ADDRESS** Boise Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28357
Registered No. 26

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 2612 W. Idaho St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME. Ida Rodgers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb 10 1871 (Month) (Day) (Year)

7. AGE: 48 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Wm Mc Ninch

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Cynthia Wilcox

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E M. Rodgers

(Address)

15. Filed 1-24 1920 L P Pfirman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 23rd 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920 to Jan 23 1920 that I last saw her alive on Jan 22 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Acute myocarditis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) T. N. Braxton M. D.

Jan 24 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/26 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

Dr. Boise Co.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28358
Registered No.

Registration District No.
Primary Registration District No. 1 6

1. PLACE OF DEATH

County of Ada
City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Hanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH Jan (Month) 1 (Day) 1889 (Year)

7. AGE 31 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER John Kenney

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country) U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edna Hanson

(Address)

15. Filed 1-24 1920 L. P. Pfirman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January (Month) 23rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19th 1920 to Jan 23rd 1920 that I last saw her alive on Jan 23 1920, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Hypopharynx with metastasis to cervical glands

(Duration) — Yrs. mos. 8 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. McCalla M. D.

1/24 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Barberton Ida

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	1/25 1920
20. UNDERTAKER	**ADDRESS**
Schreiber & Heidenfelder	Boise

McCalla

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 2

City of Boise — Primary Registration District No. 1004

(No. 809 East Jefferson St.)

File No. 28359

Registered No. 28359

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Hammon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan 28 (Month) (Day) 1871 (Year)

7. AGE: 38 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Bookkeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Phillip Hammon

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Lemoigne

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A R Pollard

(Address) Boise Idaho

15. Filed 1-26 1920

L P Plummer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22nd 1920, to Jan 24th 1920, that I last saw him alive on Jan 24th 1920, and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Flue

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Bock M. D.

Jan 24 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	1/26 1920.
20. UNDERTAKER Schreiber & Hidenfaden	ADDRESS Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
File No. 25360
Registered No.

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1001 Hays St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Moses Jouir Marks
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 23 (Day) 1837 (Year)

7. AGE: 82 Yrs. 8 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Prussia

10. NAME OF FATHER: Jouir Marks

11. BIRTHPLACE OF FATHER (State or Country): Prussia

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Prussia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs M J Marks
(Address) Boise, Ida

15. Filed 1-26 1920. L C Pfirman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6, 1920, to Jany 1920 that I last saw him alive on Jan 24 1920, and that death occurred on the date stated above, at 430 P.M.

The CAUSE OF DEATH* was as follows:
Congestion of Brain and Kidneys

(Duration) ... Yrs. ... mos. 3 ds.
Contributory (Secondary): Senility
(Duration) ... yrs. ... mos. ... ds.

(Signed) Wm B Lyman M. D.
Jan 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence: Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Jewish Cemetery — DATE OF BURIAL: 1/28 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Ada.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28361

Registered No. .....

1. PLACE OF DEATH

County of Ada

City of So Boise

(No. 1207 Colorado St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Jane Wheeler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Married

6. DATE OF BIRTH: May (Month) 4 (Day) 1856 (Year)

7. AGE: 63 Yrs. 8 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): ----------

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John Beal

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Amy Shepperson

13. BIRTHPLACE OF MOTHER (State or Country): Massachussetts

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J Ruth Wheeler
(Address) .....

15. Filed 1/27/20 19..... L P Pfirman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 21 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920 to Jan 21 1920 that I last saw h.. alive on Jan 21 1920 and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:

Dilatation of heart

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Valvular heart trouble - Asthma

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. Lyle Bucelo M. D.

1-26 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Jan 27 1920
20. UNDERTAKER	**ADDRESS**
Summers & Krebs	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Ada

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 20362

Registered No. 71

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 611 N. 16. St. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha May Packard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	White	married

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1889 (Year)

7. AGE: 30 Yrs. 4 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Chas. Jackey

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs I E Packard
(Address) Boise Ida

15. Filed 1/27/20 19 L. P. Plummer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1920 to Jan 24th 1920 that I last saw her alive on Jan 24th 1920 and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Flue

(Duration) yrs. mos. ds.

(Signed) Lotus Burke M. D.

Jan 26 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Jan 27 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25363

Registered No.

PLACE OF DEATH

County of Ada

City of Boise

(No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles W. Cathens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Unknown

6. DATE OF BIRTH: (Month) 1845 (Day) 1 (Year)

7. AGE: 75 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. E. Kreckler

(Address) Boise Idaho

15. Filed 1/27/20 19 L. P. Pfirman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 26 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Jan 26 1920, that I last saw h.. alive on Jan 26 1920 and that death occurred on the date stated above, at 1.04 M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) Carl Keefe M. D.

1/26 1920 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Jan 28 1920

20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of ce

French.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25364

Registered No.

1. **PLACE OF DEATH**

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 716 ½ Main St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Olive V. Greer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Unknown (Month) (Day) 1901 (Year)

7. AGE: 19 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Waitress

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown.

10. NAME OF FATHER: O. B. Greer

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ronald M Shertz

(Address) Hotel Mitchell - Boise

15. Filed 1/27/20 19 L P Pfirman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920, to Jan 24 1920 that I last saw h[illegible] alive on Jan 24 1920 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. ? mos. ds.

(Signed) P P French M. D.

Jan 24 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Manchester, N. H. DATE OF BURIAL: Jan 26 1920

20. UNDERTAKER: Summers & Kreb ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28365

Registered No. 4

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 1002 N. 15th St.)

Registration District No.

Primary Registration District No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Lemira D. Emrich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb - 26 - 1838
(Month) (Day) (Year)

7. AGE: 81 Yrs. 10 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: David Steer

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Anna Lincoln

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Cowan
(Address) Boise, Idaho. Nic

15. Filed 1/27 1920 L. P. Pfirrman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 25 - 1920
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1920 to Jan 25 1920
that I last saw her alive on Jan 14 1920
and that death occurred on the date stated above, at 11 30 a M.

The CAUSE OF DEATH* was as follows:

Senility,

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Carcinoma Uterus

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. J. Cluen, M. D.

1/26 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Iowa Falls, Iowa.	19
20. UNDERTAKER W. M. Bratney	ADDRESS, Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 1-25 M. 1-19.

Stewart

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No. 1004
File No. 26366
Registered No.....

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Elizabeth McCurdy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1851 (Year)

7. AGE: 69 Yrs. 0 Mos. 16 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Jacob Snyder

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Catherine Gripple

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence H. McCurdy
(Address) 210 Owyhee — Boise Ida

15. Filed 1/20 1920
L. R. Hyman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 4 1920, to Jany 18 1920
that I last saw h..... alive on Jany 18 1920
and that death occurred on the date stated above, at.....M.
The CAUSE OF DEATH* was as follows:
Paralysis
General Exhaustion
(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary)
(Duration) .....yrs.....mos.....ds.
(Signed) James L. Stewart M. D.
1/20 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Jan 21 1920
20. UNDERTAKER: Summers & Krebs | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. [redacted] -19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 20367
Registered No.

1. PLACE OF DEATH

Registration District No.

Primary Registration District No.

County of Ada

City of Boise (No. 1021 Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Himrod

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: November (Month) 4 (Day) 1842 (Year)

7. AGE: 77 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Banker

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brooklyn Tompkins Co. New York

10. NAME OF FATHER: Almond J Himrod

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sarah Van Wey

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Himrod

(Address) 1021 Jefferson St.

15. Filed 1/26 1920

L. P. Fremont
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 26 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1919, to June 12 1919, that I last saw h[illegible] alive on June 12 1919, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm T. Smith M. D.

1/28 1920 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery	1/28 1920

20. UNDERTAKER	ADDRESS
Schreiber & Sidwell	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 20368

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 410 State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lizzie Hurd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W.	Married

6. DATE OF BIRTH: Jan 23rd 1887 (Month) (Day) (Year)

7. AGE: 33 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Matt Ray Ruatsala

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Rhena Nayki.

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edmond Ruatsala
(Address)

15. Filed 1/28 1920 L. P. Pfirman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 27th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920 to Jan 24 1920
that I last saw h alive on Jan 24 1920
and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows: Acute accidental poisoning

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Pneumonia
(Duration) yrs. mos. ds.
(Signed) L J Ford M. D.
Jan 27 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 2 days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Donnelly Ida	1/29 1920
20. UNDERTAKER	ADDRESS
Schreiber & Gideon	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28369

Registered No.

Registration District No.

Primary Registration District No. 10

1. PLACE OF DEATH

County of Ada.

City of Boise.

(No. 1405. N. 14th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Docia M. Holland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White.	Widow

6. DATE OF BIRTH Aug. 13 – 1849.
(Month) (Day) (Year)

7. AGE 70 Yrs. 5 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kansas.

10. NAME OF FATHER D. M. Bivens

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Honor Jane Brawley.

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McBratney

(Address) Boise. Idaho.

15. Filed 1/27 1920

L G Gunnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 27 – 1920
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 11 1920 to Jany 27 1920 that I last saw h.er alive on Jany 24 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Edward L Doan M. D.

1/28 1920 (Address) Boise. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette - Idaho.	1/29 1920.

20. UNDERTAKER	ADDRESS
W. McBratney	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Hill.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28370

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St. Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie Cooper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 24 1893
(Month) (Day) (Year)

7. AGE: 26 Yrs. 1 Mos. 1 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Cooper

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Rose Rathbone

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Cooper.

(Address) Boise Idaho.

15. Filed Jan 29 1920

L. O. Thomas
Local Registrar

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 25 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920, to Jan 25 1920, that I last saw h-er alive on Jan 25 1920, and that death occurred on the date stated above, at 2: P.M.

The CAUSE OF DEATH* was as follows:

Influenza and pneumonia,

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Earl Hill M. D.

1/29 1920 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Jan 28 1920

20. UNDERTAKER: Summers & Krebs

ADDRESS: Boise, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

Pittenger

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
File No. 25371
Registered No.....

1. **PLACE OF DEATH**
County of Ada
City of Boise.
(No. 1711 Resique St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Robert E. Whittle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: M.

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: Sep 25 (Month) (Day) 1918 (Year)

7. **AGE**: 1 Yrs. 4 Mos. 2 ds.
IF LESS than 1 day how many.....hrs. or.....min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. **BIRTHPLACE** (State or Country): Idaho.

10. **NAME OF FATHER**: Lester R. Whittle.

11. **BIRTHPLACE OF FATHER** (State or Country): Illinois

12. **MAIDEN NAME OF MOTHER**: Avis Smyth.

13. **BIRTHPLACE OF MOTHER** (State or Country): Oregon

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) O. J. Whittle
(Address).....

15. Filed Jan 29 1920 L. O. Pfunner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Jan 27 (Month) (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan 23 1920, to Jan 27 1920, that I last saw him alive on Jan 27 1920, and that death occurred on the date stated above, at 1 P. M.

The **CAUSE OF DEATH*** was as follows:

Bronchopneumonia

(Duration).....Yrs.....mos.....ds.

Contributory (Secondary) Influenza

(Duration).....yrs.....mos.....ds.

(Signed) F. O. Pettengill M. D.

1/29 1920 (Address) Boise Id

*State the Disease Causing Death; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Morris Hill Cem. **DATE OF BURIAL**: Jan 29 1920

20. **UNDERTAKER**: Summers & Koch. **ADDRESS**: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

County of Ada — Registration District No. ____
City of Boise — Primary Registration District No. ____ — (No. 410 State St.) — File No. 2032 — Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julian Subisarretta

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 1890 (Month) (Day) (Year)

7. AGE: 30 Yrs. ____ Mos. ____ ds. — IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheepherder
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Pedro Subisarretta

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): ~~Dont~~ Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jerwin + Zubisarreta
(Address) ____

15. Filed Jan 29 1920 — L. P. Inman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1920 to Jan 27 1920 that I last saw him alive on Jan 26 1920 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar
Double
Influenza.

(Duration) ____ Yrs. ____ mos. 2 ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration) 4 yrs. ____ mos. ____ ds.

(Signed) Ralph Hall M. D.

1/27 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence Idaho.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	1/30 1920
20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE of death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of this sheet.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28373

Registered No. ____

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. ____

Primary Registration District No. 1005

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME May E. Sherrill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female | 4. COLOR OR RACE: White | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 27 (Day) 1882 (Year)

7. AGE: 37 Yrs. 7 Mos. 28 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Malta Idaho

10. NAME OF FATHER: W. K. Abercrombie

11. BIRTHPLACE OF FATHER (State or Country): Ark.

12. MAIDEN NAME OF MOTHER: Martha ____

13. BIRTHPLACE OF MOTHER (State or Country): Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Sherrill
(Address) ____

15. Filed Jan 29 1920 L. O. Gasman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920 to Jan 24 1920 that I last saw h[e]r alive on Jan 24 1920 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Influenza & Bronchial Pneumonia

(Duration) ____ Yrs. ____ mos. 7 ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) O. Ben L. O. Burke M. D.

1/26 1920 (Address) 410 Idaho St. Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 1/30 1920

20. UNDERTAKER: Schreiber & Siebenfaden | ADDRESS: Boise, Ida

Dr Burke

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 1104
File No. 28374
Registered No. 42

1. PLACE OF DEATH
County of Ada
City of Boise (No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillie M. Holt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 29 (Day) 1882 (Year)

7. AGE: 39 Yrs. 5 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: W. D. Lockhart

11. BIRTHPLACE OF FATHER (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Alice E. Chase

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thurston Holt
(Address) Hammett Ida

15. Filed 1/18 1920 L. O. Forman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1920, to Jan 18 1920
that I last saw h[illegible] alive on Jan 17 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Septicemia puerperal
following abortion
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Damage Myocardium
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
1/19 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Hammett Ida

19. PLACE OF BURIAL OR REMOVAL: Baker City Ore. DATE OF BURIAL: 1/19 1920

20. UNDERTAKER: Schroeder & Hildreth ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 1301, N. 10th St. St.)

File No. 20375

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Furre Murray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word): Married

6. DATE OF BIRTH: April 29th 1870 (Month) (Day) (Year)

7. AGE: 49 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alma, Wis

10. NAME OF FATHER: Chas. Furre

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Barbara Schad

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer Murray

(Address) 1301 N 10 St

15. Filed Jan 29 1920 L. O. Jones Local Registrar

Dr. Titus

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 28th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1920, to Jan 28 1920

that I last saw h-r alive on Jan 27 1920

and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Double)

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. 5 ds.

(Signed) W S Titus M. D.

1-28 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Harris Hill Cemetery — DATE OF BURIAL: 1/30 1920

20. UNDERTAKER: Schreiber & Siebenpfeffer — ADDRESS: (Boise)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 20376

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 608, Washington St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert W. Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 17 (Day) 1882 (Year)

7. AGE: 37 Yrs. 2 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Accountant

(b) General nature of industry, business or establishment in which employed (or employer): Deputy County Treasurer Ada County, Idaho

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: Otto W. Peterson

11. BIRTHPLACE OF FATHER (State or Country): Schleiswig, Denmark

12. MAIDEN NAME OF MOTHER: Rachel Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Hanover Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Otto Peterson

(Address) Boise, Idaho

15. Filed Jan 30 1920 L. O. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1920 to Jan 23 1920 that I last saw h[illegible] alive on Jan 22 1920 and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia a following Flue - complicated with asthma

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

1-23 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/1 1920

20. UNDERTAKER: Schreiber & Adkins — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
File No. 28377
Registered No.

1. PLACE OF DEATH
County of Ada
City of Boise (No. 460 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Mae Fisher
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 11th (Day) 1894 (Year)

7. AGE: 25 yrs 10 mos 18 ds
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vernon Co. Mo.

10. NAME OF FATHER: L. C. Polley

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Cora Mabee

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theodore A. Fisher
(Address)

15. Filed Jan 30 1920 L. O. Thurman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27 1920 to Jan 28 1920 that I last saw her alive on Jan 28 1920, and that death occurred on the date stated at 3P M.

The CAUSE OF DEATH* was as follows:
Double pneumonia (Coton)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) L. P. McCalla M. D.

1/29 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Eagle Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Feb 1 1920

20. UNDERTAKER: Schreiber & Eidemiller | ADDRESS: Boise

Dr McCalla

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Boston

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 20378

Registered No. 47

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 110 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorothy Burtch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH: Sept 1918 (Month) (Day) (Year)

7. AGE: 1 Yrs. 4 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Idaho

15. Filed 1/27 1920 L O Forman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to Jan 29 1920, that I last saw her alive on Jan 29 1920, and that death occurred on the date stated above, at [redacted] 9 P M

The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(Duration) Yrs. mos. 24 ds.

Contributory (Secondary) Acute Myocarditis

(Duration) yrs. mos. 2 ds.

(Signed) T. F. Brayton M. D.

Jan 30 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: County Cemetery | DATE OF BURIAL: Jan 30 1920

20. UNDERTAKER: Summers & Reed | ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2870

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

2. FULL NAME Silvestre Orueta

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Spanish

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. December 31 (Month) (Day) 1893 (Year)

7. AGE: 19 Yrs. ..... Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheepman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Navarra Viscaya Spain

10. NAME OF FATHER: Juan Jose Orueta

11. BIRTHPLACE OF FATHER (State or Country): Ezeno Viscaya Spain

12. MAIDEN NAME OF MOTHER: Josefa Castanos

13. BIRTHPLACE OF MOTHER (State or Country): Navarra Viscaya Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Martin Etcharte
(Address) Mt Home Idaho

15. Filed ..... 191.....
L. P. Pferman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 1st (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2nd 1920 to ..... 191.., that I last saw him alive on Dec Jan 3 1920 and that death occured on the date stated above, at about 8 A. M.

The CAUSE OF DEATH* was as follows: Accidently Killed from being thrown from a Wagon

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Shumway M.D.

1/5 1920 (Address) Boise Idaho

* State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Home Idaho — DATE OF BURIAL: 1/5 1920

20. UNDERTAKER: A W Conover — ADDRESS: Mt Home Idaho

BYNS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2005
File No. 28381
Registered No. 26

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruben Eells
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1911 (Year)

7. AGE: 8 Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Otis Eells

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Edna Gannett

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James R Biggs
(Address) Caldwell Ida #4

15. Filed 2-6-1920
John L Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:
Typhoid fever
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) T. Lux.
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W Peckham Coroner
19..... (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cem — DATE OF BURIAL: 2-7-1920
20. UNDERTAKER: Care F H Co — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1005
(No. ..... St.)

File No. 20382
Registered No. 93

1. PLACE OF DEATH
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Martha A Tolson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: April (Month) 20 (Day) 86[illegible] (Year)

7. AGE: 54 Yrs. 6 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER Isaac Newman

11. BIRTHPLACE OF FATHER (State or Country) K[illegible]

12. MAIDEN NAME OF MOTHER Elizabeth C. Bryant

13. BIRTHPLACE OF MOTHER (State or Country) [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) Caldwell, Ida.

15. Filed 2-7-1920 John L Smyser
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920 to Feb 6 1920
that I last saw her alive on Feb 6 1920
and that death occurred on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows: Pneumonia following flu

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Lem M. D.
2/7 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: FEB 8 1920

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2005
File No. 28383
Registered No. 24

1. **PLACE OF DEATH**
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Juanita Brock
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** female
4. **COLOR OR RACE** white
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.)

6. **DATE OF BIRTH** Oct (Month) 12 (Day) 1916 (Year)

7. **AGE** 3 Yrs. 3 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Missouri

10. **NAME OF FATHER** Calvin Brock

11. **BIRTHPLACE OF FATHER** (State or Country) Miss

12. **MAIDEN NAME OF MOTHER** Dora Richlyter

13. **BIRTHPLACE OF MOTHER** (State or Country) Ark.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) W. S. Whete
(Address) Caldwell, Ida

15. Filed 2-6-1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920 to Feb 3rd 1920, that I last saw h.er alive on Feb 2 1920 and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Scarlet fever —

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) fire - Clothing

Complicated — Chronic

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Whete M. D.

2/6 1920 (Address) Caldwell Ida

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** canyon Hill — **DATE OF BURIAL** 2-6 1920

20. **UNDERTAKER** base Funeral — **ADDRESS** Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 28384
Registered No. 23

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J H De Moss
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Feb (Month) 3 (Day) 1 (Year)

7. AGE: 46 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Herder
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. S. Smith
(Address) Payette Idaho

15. Filed 2-3-1920 John L. Myers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Gun shot wound through brain.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. V. Leftwich Coroner
19..... (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill Cemetery
DATE OF BURIAL: 2-4-1920

20. UNDERTAKER: P. L. Case
ADDRESS: Cald

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 1005

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 20385

Registered No. 22

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Adeline Josephine D'Moss

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1854 (Year)

7. AGE: 35 Yrs. 3 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: M. S. Smith

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Clara J. Rice

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. S. Smith

(Address) .....

15. Filed 2-3- 1920 John L. Mayes Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun shot wound ten inches above heart and one through right lung.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Chapman M.D.

..... 19..... (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho

DATE OF BURIAL ..... 19.....

20. UNDERTAKER .....

ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 28386
Registered No. 21

1. PLACE OF DEATH.
County of Canyon
City of Greenleaf
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Calvin Harvey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. March 29 1847
(Month) (Day) (Year)

7. AGE: 72 Yrs. 10 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indianna

10. NAME OF FATHER: David Harvey

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Mary

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Calvin Harvey
(Address) Greenleaf Idaho

15. Filed 2-5- 1920 John S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & BOXS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12th 1920, to Jan. 31st 1920, that I last saw him alive on Jan 31st 1920 and that death occured on the date stated above, at 7-30 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1½ Yrs. — mos. ..... ds.

Contributory (Secondary) —

(Duration — yrs. — mos. ..... ds.

(Signed) J. M. Henry M. D.

Feb 4 1920 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenleaf Cem — DATE OF BURIAL: 2-5 1920

20. UNDERTAKER: E. E. Beckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2487

Registered No. 28281

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilbur Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 2 (Day) 1919 (Year)

7. AGE: ..... Yrs. 10 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER C. A. Miller

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Delight Bacon

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. A. Miller

(Address) Caldwell, Ida.

15. Filed 2-7-1920 John D. Inmyes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 30 1920, to Feb. 2 1920, that I last saw h[illegible] alive on Feb 2 1920 and that death occured on the date stated above, at 8-A M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia subsequent to Epidemic Influenza

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Epidemic Influenza

..... (Duration ..... yrs. ..... mos. 3 ds.

(Signed) R. J. Young M. D.

2-3 1920 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Canyon Hill — DATE OF BURIAL 2-8 1920

20. UNDERTAKER E. E. Kellham — ADDRESS Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 1005
File No. 28388
Registered No. 19

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Simon B. Dement (Dement)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Sept (Month) 10 (Day) 1844 (Year)

7. AGE: 75 Yrs. 4 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo W Dement
(Address) Caldwell Ida

15. Filed 2-6-1920 John L. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1920, to Feb 2 1920, that I last saw h.. alive on Feb 2 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Fracture of the base of the skull.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. J. Young M. D.
Feb 6 1920 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 1920

20. UNDERTAKER: E. L. Lowe
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 25389
Registered No. 18

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archie Lee White
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June 17 (Month) (Day) 1911 (Year)

7. AGE: ..... Yrs. 7 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ira A. White

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Lillie Mc[illegible] Smith

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira A. White
(Address) .....

15. Filed 2-6-1920 John V. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 2 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1920 to Feby 2 1920 that I last saw him alive on Feby 2 1920, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Croupous Pneumonia
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Stanner M. D.
2-3-1920 (Address) Middleton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: [illegible] Co. — ADDRESS [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 25390
Registered No. 77

1. PLACE OF DEATH.
County of Canyon
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Boyd Gurwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 20 (Day) 1899 (Year)

7. AGE: 20 Yrs. 5 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: C. L. Gurwell.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Ruth Anne Bassett

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C C Gurwell
(Address) Caldwell, Ida.

15. Filed 2-3-1920 John V. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1920, to Feb. 1 1920, that I last saw h..... alive on Feb. 1 1920 and that death occured on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows: Influenza Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

2-2 1920 (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 2-3 1920

20. UNDERTAKER: E. F. Peckham ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1005
File No. 2091
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel Pearl Fillmore
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 1 (Day) 1890 (Year)

7. AGE: 29 Yrs. 10 Mos. 30 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: John J. Burbank

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Lama V. Herin

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Burbank
(Address) Latham Nebr

15. Filed 2-2- 1920 John J. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1920, to Jan 31 1920, that I last saw her alive on Jan 31 1920, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary) pregnancy & delivery & pneumonia

(Duration) yrs. 7½ mos. ds.

(Signed) J. W. Gee M. D.

2/2 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill Cemetery — DATE OF BURIAL: 2-2-1920

20. UNDERTAKER: P. L. Case — ADDRESS: Cald

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 28392
Registered No. 13

1. PLACE OF DEATH.
County of Canyon
City of Middleton
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Fannie Dyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec. (Month) 2 (Day) 1849 (Year)

7. AGE: 52 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Alexander Thompson

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Elizabeth Crumb

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. D. Dyer
(Address) Caldwell R.D. 1

15. Filed 2-1-1920 John L. Ireys Local Registrar

SYMS - YORK CO., PTRS. & RDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Jan 31 1920, that I last saw her alive on Jan 27 — 1920, and that death occured on the date stated above, at 7 M.

The CAUSE OF DEATH* was as follows:
Renewed attack of Chronic Nephritis

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Influenza & Pneumonia
(Duration yrs. mos. 2 ds.
(Signed) Wm W Thomson M. D.
2-1-1920 (Address) Middleton Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Middleton, Ida
DATE OF BURIAL: Feb 1 1920

20. UNDERTAKER: C. V. Peckham
ADDRESS: Caldwell, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 3

Primary Registration District No. 2045

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28393

Registered No. 44

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH.

County of Canyon

City of Middleton

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chester Arthur Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Nov. (Month) 20 (Day) 1889 (Year)

7. AGE: 30 Yrs. 2 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William F. Smith

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Lauccamp

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. F. Smith

(Address) Middleton Ida.

15. Filed 1-29- 1920

John S. Jones
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1920, to Jan 26 1920, that I last saw him alive on Jan 26 1920, and that death occured on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Trouble
and Gastritis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Hamer M. D.

19..... (Address) Middleton Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Middleton — DATE OF BURIAL: 1-28 1920

20. UNDERTAKER: C. C. Peckham — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 20394
Registered No. 13

1. PLACE OF DEATH.
County of Canyon
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Effie Blankenship
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. April 27 (Month) (Day) 1848 (Year)

7. AGE: 71 Yrs. 9 Mos. ds.
IF LESS than 1 day how many ..... hrs. of ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Holland

10. NAME OF FATHER: Peter Arema

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Wietsche Ypma

13. BIRTHPLACE OF MOTHER (State or Country): Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John B Blankenship
(Address) Caldwell, Ida

15. Filed 1-31- 1920
John V. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Jan 27 1920, that I last saw her alive on Jan 27 1920 and that death occured on the date stated above, at 2-300 M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Chr. Nephritis
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) M. D. Kelly M. D.
1-31 1920 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview Cem Minnesota — DATE OF BURIAL: 191

20. UNDERTAKER: E. Beckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 28395
Registered No. 12

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fr. James A. Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 28 (Day) 1878 (Year)

7. AGE: 41 Yrs. 7 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rankin Co Miss.

10. NAME OF FATHER: James L. Young

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C Clendenon
(Address) Boise Idaho

15. Filed 1-21-1920 John U. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h..... alive on ..... 19...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia,
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary)
.....(Duration) .....Yrs.....mos.....ds.
(Signed) C. S. Peckham Coroner
19..... (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Jan 22 1920

20. UNDERTAKER: Case Furniture Co — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 25396
Registered No. 77

1. PLACE OF DEATH.
County of Canyon
City of Caldwell (#1) (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred May Mount

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 15 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Waren E Mount

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Cora Seagarden

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas Seagarden
(Address) Caldwell Ida #1

15. Filed 1-20- 1920 John L. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1920, to Jan 19 1920, that I last saw her alive on Jan 19 1920, and that death occured on the date stated above, at 7.10 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Cem. DATE OF BURIAL: 1-20 1920

20. UNDERTAKER: Peckham F.H. & Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & RORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... , ... St.)

File No. 28397
Registered No. 10

1. PLACE OF DEATH.

County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claude E Brittingham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) married

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1874 (Year)

7. AGE 45 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Rancher

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Frank Brittingham

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Mary Maupdon

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F B Brittingham

(Address) Vale, Oregon

15.

Filed 1-18-1920 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at 12-20 A.M.

The CAUSE OF DEATH* was as follows: Cardiac Embolism

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. V. Beckham Coroner

19..... (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Vale, Oregon — **DATE OF BURIAL** ..... 191...

20. UNDERTAKER Beckham & J. V. Co — **ADDRESS** Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 28398
Registered No. 9

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie N. S. Dils

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write word.)

6. DATE OF BIRTH. Apr. (Month) 18 (Day) 1842 (Year)

7. AGE 77 Yrs. 8 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeping
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Jackson Shurley

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Mary Mineau

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) N. S. Dils
(Address) Caldwell, Idaho

15. Filed 1-20- 1920
J. L. G. Ireys
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Dropsy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. V. Beckham Grover, M.D.
19..... (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 1-20 1920

20. UNDERTAKER: Beckham F. H. Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2005
(No. ..... , ... St.)

File No. 2039
Registered No. 8

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas T. Johnston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1.27 (Year)

7. AGE: 83 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranches
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Thomas Johnston

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Frankie Satterfield

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J F Johnston
(Address) [illegible]

15. Filed 1-18-1920 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1920 to Jan 17 1920
that I last saw him alive on Jan 17 1920
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Arterio sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Lee M. D.
1/18 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Jan 19 1920

20. UNDERTAKER: Cole Fun. Co. — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25400

Registered No. 7

1. PLACE OF DEATH.

County of Owyhee

City of Homedale (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stella E. Kaschmick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct (Month) 7 (Day) 1885 (Year)

7. AGE: 34 Yrs. 2 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Robt Alexander

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Laura Hickman

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Otto A Koschmick
(Address) Homedale Idaho

15. Filed 1-19- 1920 John L. Meyer Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 11, 1920, to January 16, 1920, that I last saw her alive on January 15, 1920, and that death occured on the date stated above, at 9-20 A.M.

The CAUSE OF DEATH* was as follows:

Puerperal septicemia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): miscarriage

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.

Jan 16 1920 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. 6 days. In the State .....yrs. .....mos. .....days

Where was disease contracted if not at place of death? Home

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 1-19 1920

20. UNDERTAKER: Beckham & Caldwell — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 20401
Registered No. .....

1. PLACE OF DEATH.
County of Owyhee
City of Homedale

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Juanita Fay Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. March 14 1919
(Month) (Day) (Year)

7. AGE: ..... Yrs. 9 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work. At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J A Jackson

11. BIRTHPLACE OF FATHER (State or Country) California

12. MAIDEN NAME OF MOTHER Ora G Wilson

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P G Wilson
(Address) Homedale, Idaho

15.
Filed 1-14- 1920 John D. Meyer - Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920, to Jan 12 1920, that I last saw her alive on Jan 12 1920, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A W Smith M. D.
Jan 1920 (Address) Wilder Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 1-13-1920

20. UNDERTAKER: Peckham F H Co — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 28402
Registered No. 5

1. PLACE OF DEATH.
County of Canyon
City of Caldwell #2 (No. Rural # 2 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alva Lauren Farmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. Jan (Month) 18 (Day) 1919 (Year)

7. AGE — Yrs. 11 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Kirk. Farmer.

11. BIRTHPLACE OF FATHER (State or Country) Arkansaw.

12. MAIDEN NAME OF MOTHER Alva Packer

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Kirk Farmer
(Address) Caldwell Ida #2

15. Filed 1-8-1920 John D. Meyer - Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 — 1920, to Jan 6 1920, that I last saw him alive on Jan 6 1920, and that death occured on the date stated above, at 8-30a M.

The CAUSE OF DEATH* was as follows:
Croupous Pneumonia

(Duration) ..... Yrs. ..... mos. 2 — ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) L. W. Varner M. D.
1/7 1920 (Address) Middleton Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton — DATE OF BURIAL: 1-8 1920

20. UNDERTAKER: Packham F & M Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 3

County of Canyon Primary Registration District No. 2005

City of Caldwell (No. ..... St.) File No. 25403

If death occurs away from usual residence, give facts called for under special information. Wilder

2. FULL NAME Geo. Nelson Miller.

Registered No. 4

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1868 (Year)

7. AGE: 51 yrs. 10 mos. 19 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Levy Miller.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Julia Stevens

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W. R. Sample
(Address) Wilder Idaho

15. Filed 1-5- 1920 John P. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1920 to Jan 4 1920 that I last saw him alive on Jan 3 1920 and that death occurred on the date stated above, at 6A. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) Uremic Coma

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. M. Mitchell M. D.

1/4 1920 (Address) Parma Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Woodbine Iowa | DATE OF BURIAL ..... 191..

20. UNDERTAKER: Peckham Co. | ADDRESS: Caldwell

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2004
File No. 25404
Registered No. 3

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raphael Cleveland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 23 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): South Carolina

10. NAME OF FATHER: Robert E. Cleveland

11. BIRTHPLACE OF FATHER (State or Country): South Carolina

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nephew Andrew
(Address) Caldwell, Ida.

15. Filed 1-6-1920 John L. Meyer Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Jan (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 2-P. M.
The CAUSE OF DEATH* was as follows:
Crushing & scalding by electric car.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. V. Peckham Coroner
19... (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby Idaho — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Peckham F. H. Co. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 8

Primary Registration District No. 2005

File No. 25405

Registered No. 25

County of Canyon

City of Middleton (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mattie Francis Hickerson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 21 (Day) 1858 (Year)

7. AGE 62 Yrs. 5 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Missouri.

10. NAME OF FATHER J. K. Bell.

11. BIRTHPLACE OF FATHER (State or Country) Missouri.

12. MAIDEN NAME OF MOTHER Mary B. Jacks.

13. BIRTHPLACE OF MOTHER (State or Country) Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Hickerson
(Address) Caldwell, Ida.

15. Filed 1-3- 1920 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1917, to Jan 2 1920, that I last saw her alive on Jan 1 1920 and that death occured on the date stated above, at 3-30 P.M.

The CAUSE OF DEATH* was as follows: Carcinoma of Uterus

(Duration) 1½ Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. M. Kelley M. D.

1-3 1920 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 1-3 1920

20. UNDERTAKER: Redman Case Co. ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon
City of Middleton
(No. ....., ... St.)

Registration District No. 3
Primary Registration District No. 2005

File No. 28406
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abraham Lincoln Ragsdale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH. May (Month) 25 (Day) 1861 (Year)

7. AGE: 58 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Jarvel Ragsdale

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Malinda Wisdom

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Ragsdale
(Address) Middleton, Idaho

15. Filed 1-9- 1920 John S. Meyer Local Registrar

SVMS - YORK CO., PTRS. & SDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Jan (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14, 1919, to Jan 1, 1920, that I last saw him alive on Jan 1 1920, and that death occured on the date stated above, at 1-30P M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Young M. D.

Jan 7, 1920 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Jan 3 1919

20. UNDERTAKER: Beckham Case & Caldwell ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28408

Registered No.

Registration District No. 821

Primary Registration District No.

(No. ..... St.)

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs E. Sweet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 11 (Day) 1852 (Year)

7. AGE: 67 Yrs. ..... Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Hylin

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Ellen McQuaga

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Sweet

(Address) Sweet, Idaho

15. Filed 1-8 1920

J. E. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15 1919, to Jan 4 1920 that I last saw h[er] alive on Jan 3 1920, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Gastric

(Duration) 2½ Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis & Byrd M. D.

1/4 1920 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sweet Idaho

DATE OF BURIAL: 1/6 1920

20. UNDERTAKER: C. D. Bucknum

ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fayette
City of Falks
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1020
Primary Registration District No.
(No. , St.)

File No. 28410
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Stena Rasmussen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word.): Married

6. DATE OF BIRTH: Jan (Month) 8 (Day) 1 (Year)

7. AGE: 54 yrs. — mos. 22 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Known

10. NAME OF FATHER: Chris Keegard

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Inga Rasmussen
(Address): Falk Idaho

15.
Filed Feb 3 1920 J. W. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Jan 30 1920, that I last saw her alive on Jan 30 1920, and that death occurred on the date stated above, at 9 30 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory (Secondary): Epidemic Influenza

(Duration) yrs. mos. 6 ds.

(Signed) Wm T. Reynolds M. D.
1-31- 1920 (Address) Fern Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Falks Ida
DATE OF BURIAL: Feb 1 1920

20. UNDERTAKER: C. L. Buckmun
ADDRESS: Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1021
Primary Registration District No.
(No. , St.)
File No. 28411
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Anna Bean
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Infant

6. DATE OF BIRTH: Jan (Month) 10 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harry R. Bean

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Naoma Tallman

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry R Bean
(Address) Emmett Ida

15. Filed 1-15-1920 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth, to 19..., that I last saw h... alive on 19..., and that death occurred on the date stated above, at ...M.
The CAUSE OF DEATH* was as follows:
Premature birth due to Eclampsia in Mother
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. L. Reynolds M. D.
1-15 1920 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Plymouth Ida	1/14 1920

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of [illegible]

City of [illegible]

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 10 W

(No. , St.)

File No. 2841 2

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Owen McWilliams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: July 12 (Month) (Day) 1857 (Year)

7. AGE: 62 Yrs. 7 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Construction Foreman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William McWilliams

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Mary Cummins

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. O. McWilliams

(Address) Emmett Idaho

15. Filed 2/13 1920

J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 15 (Month) (Day) 12 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7 6 9 1920 to 7 12 12 1920, that I last saw h[illegible] alive on 7 6 11 1920, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(Duration) unknown Yrs. mos. ds.

Contributory (Secondary) Arteriosclerosis

(Duration) yrs. mos. 3 ds.

(Signed) Lucian S. Byrd M. D.

7/13 1920 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho

DATE OF BURIAL: 2/14 1920

20. UNDERTAKER: O. D. Bucknum

ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1010
Primary Registration District No.
File No. 2841?
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sukeichiro Yamada
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: asiatic
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: July (Month) 15 (Day) 1877 (Year)

7. AGE: 42 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Resturarant Prop.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: not Known

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. W. Swearin
(Address) Emmett Idaho

15. Filed Feb 3 1920 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1920 (Year)
Jan 24 1920

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920, to Jan 30 1920
that I last saw him alive on Jan 30 1920
and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 8 ds.

(Signed) J. L. Reynolds M. D.
2/3 1920 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: Feb 1 1920

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1011
Primary Registration District No.
File No. 28414
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hazel Virginia Douglas
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: May 6 1900 (Month) (Day) (Year)

7. AGE: 19 Yrs. 8 Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: William Franklin Edwards

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Emma Tryon

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Douglas
(Address) Emmett Idaho

15. Filed Feb 2 1920 J. C. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920 to Jan 29 1920, that I last saw h[illegible] alive on Jan 29 1920, and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary): Influenza
(Duration) yrs. mos. 10 ds.

(Signed) Burton O Clark M. D.
Jan 30 1920 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho
DATE OF BURIAL: 19
20. UNDERTAKER: C. D. Beckner
ADDRESS: Emmett Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28415

Registered No.

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1070

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jessie Thomas Hawkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: February (Month) 2 (Day) 1858 (Year)

7. AGE: 61 Yrs. 4 Mos. 25 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Polk Co Missouri

10. NAME OF FATHER: Ozias Hawkins

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Percella Meadows

13. BIRTHPLACE OF MOTHER (State or Country): Nashville Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ellen Hawkins

(Address) Emmett Idaho

15. Filed 2/5 1920 J. K. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 2 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1920, to Feb 2 1920, that I last saw him alive on " " 1920, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. about 6 mos. 7 ds.

Contributory (Secondary) Influenza & Cerebral hemorrhage

(Duration) yrs. mos. ds.

(Signed) Wm S. Drysdale M. D.

2-4 1920 (Address) New Plymouth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho | DATE OF BURIAL: 2/4 1920

20. UNDERTAKER: C. O. Buckmun | ADDRESS: Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28416

Registered No.

1. PLACE OF DEATH

County of Gem

City of Emmett

(No. ..... St.)

Registration District No. .....

Primary Registration District No. 1010

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherine Gilbride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 18 (Day) 1901 (Year)

7. AGE: 18 Yrs. 4 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Michael Gilbride

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Ellen Moore

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Michael Gilbride

(Address) Emmett Ida

15. Filed 2/7 1920

J. D. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1920, to Feb 4 1920, that I last saw h.e.r alive on Feb 4 1920, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Acute General peritonitis

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Reynolds M. D.

19 ..... (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 2/6 1920

20. UNDERTAKER: C. D. Buckner

ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28417
Registered No.

Registration District No. Vacinity
Primary Registration District No. 1026

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. 2, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widower

6. DATE OF BIRTH: Jan (Month) 27 (Day) 1852 (Year)

7. AGE: 67 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Willis Smith

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George T. Smith
(Address) Emmett Idaho

15. Filed 1-12 1920
J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1919, to Dec 29 1919, that I last saw him alive on Dec 29 1919, and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Hematemesis
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Gastric Ulcer
(Duration) Several yrs. mos. ds.
(Signed) R N Cummings M. D.
1/11 1920 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Murray Utah
DATE OF BURIAL 19

20. UNDERTAKER: C. A. Buckenmyer
ADDRESS Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 28418
Registered No. .....

1. PLACE OF DEATH
County of Gem
City of Emmett

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrle Frank Washburn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Infant

6. DATE OF BIRTH
Aug (Month) 13 (Day) 1919 (Year)

7. AGE
— Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER E. H. Washburn

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Elsie Fuller

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. H. Washburn
(Address) Emmett Ida

15. Filed Feb 9 1920 J. K. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to Feb 7 1920, that I last saw him alive on Feb 7 1920, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J. S. Reynolds M. D.
2/9 1920 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Ida.	2/8 1920
20. UNDERTAKER C. L. Buckner	ADDRESS Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

File No. 28419

County of Canyon

City of Melba (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nora Ethel Haynes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: November (Month) 14 (Day) 1893 (Year)

7. AGE: 26 yrs. 2 mos. 7 ds.

IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Buffalo, Mo.

10. NAME OF FATHER: H. S. Haynes

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: C. P. Arnold

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. H. S. Haynes
(Address) Melba Idaho

15. Filed Feb. 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191 to Feb 7 1920
that I last saw her alive on Feb 7 1920
and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia -
.....
.....
(Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Calverman M. D.
2-8 1920 (Address) Kuna Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Melba Ida — DATE OF BURIAL: 2-8 1920

20. UNDERTAKER: H K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 28420
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Kuna (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lester E. Schofield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	

6. DATE OF BIRTH: April (Month) 16 (Day) 1919 (Year)

7. AGE: yrs. 9 mos. ds. IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kuna Ida

10. NAME OF FATHER O. E. Schofield

11. BIRTHPLACE OF FATHER (State or Country) Mich

12. MAIDEN NAME OF MOTHER Mary Jackson

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. E. Schofield
(Address) Kuna Ida

15. Filed Feb. 9 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-7-1920 191 , to 2-7-1920 191 , that I last saw him alive on 2-7- 1920, and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:
Intestinal Hemorrhage.
(Illness cause.)
(Duration) yrs. mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. 5 ds.
(Signed) H. D. Smith M. D.
2-8-1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF REMOVAL: Kuna Ida | DATE OF BURIAL: 2-10 1920

20. UNDERTAKER: F. P. Robinson | ADDRESS: Nampa

H. D. Smith

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28421

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Melba

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Loomis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 18 (Day) 1920 (Year)

7. AGE: 53 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Hammer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ark

10. NAME OF FATHER: John Loomis

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Martha Raymon

13. BIRTHPLACE OF MOTHER (State or Country): Ark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wm Loomis

(Address) .....

15. Filed Feb. 10 1920 Pearle Dodds, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920 to Jan 31 1920, that I last saw him alive on Jan 31 1920 and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Int Influenza

.....

.....

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Thos. E. Maguire M. D.

2/5 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Melba Idaho — DATE OF BURIAL: 2-2 1920

20. UNDERTAKER: H. T. Robinson — ADDRESS

Marquam, 17

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

9 #2

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1006
(No. ....., ... St.)

File No. 28422
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Adah M^c Bane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 27 (Day) 1885 (Year)

7. AGE: 35 yrs. 10 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Abram Newton

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Cochran

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. I. Mc Bane
(Address) Nampa Idaho.

15. Filed Feb. 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-1 1920, to 2-6 1920 that I last saw h^er alive on 2-6 1920 and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:
Cardiac Exhaustion, due
to toxemia Sequela of
Influenza
(Duration) ..... yrs. ..... mos. 7 ds.
Contributory Bronchitis
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. C. Robinson M. D.
2/9 1920 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: | DATE OF BURIAL: 2-10 1920

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28423
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. .... St.)
Registration District No. 7
Primary Registration District No. 2006
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME [redacted] Donald McLaysen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 26 (Day) 1919 (Year)

7. AGE [redacted] Yrs. 5 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Gooding, Ida

10. NAME OF FATHER: John McLaysen

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Hazel Bonney

13. BIRTHPLACE OF MOTHER (State or Country): Oreg —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James McClaysen
(Address) Nampa

15. Filed Feb. 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1920, to Feb 6 1920, that I last saw him alive on Feb 5 1920, and that death occured on the date stated above, at 1300 M.

The CAUSE OF DEATH* was as follows:
Whooping Cough &
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Whoop Cough 5 Wks
Pneumonia (Duration ..... yrs. ..... mos. 3 ds.

(Signed) [redacted] M. D.
2-6 1920 (Address) [redacted] Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverview Cem
DATE OF BURIAL: 2-8 1920

20. UNDERTAKER: F. H. Robinson
ADDRESS: Nampa

Coleman

BYNS - YORK CO., PTRS. & BOKS. 24658

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 28424
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo Conrad.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 18 (Day) 1904 (Year)

7. AGE: 15 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ino

10. NAME OF FATHER: G. A. Conrad

11. BIRTHPLACE OF FATHER (State or Country): Ino

12. MAIDEN NAME OF MOTHER: Mary Linteau

13. BIRTHPLACE OF MOTHER (State or Country): Ino

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. A. Conrad.
(Address) Nampa Ida.

15. Filed Feb. 18 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 5, 1920
Feb 5 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920, to Feb 5 1920, that I last saw h[illegible] alive on Feb 4 1920, and that death occured on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:
Scarlet fever
.....
.....
.....(Duration) .....Yrs. .....mos. Six ds.

Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.

(Signed) O. Meredith M.D.
By Mrs. O. Meredith
1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rochester Cem. | DATE OF BURIAL: 2-6 1920

20. UNDERTAKER: F. F. Robinson | ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

(Meredith)

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1886
File No. 28425
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elliott N. Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. July (Month) 17 (Day) 1917 (Year)
7. AGE 2 Yrs. 7 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Minersville Utah
10. NAME OF FATHER Henry F. Baker
11. BIRTHPLACE OF FATHER (State or Country) Utah
12. MAIDEN NAME OF MOTHER Amy Walker
13. BIRTHPLACE OF MOTHER (State or Country) Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry F. Baker
(Address) Nampa Ida
15. Filed Feb. 10 1920 Pearle Dodds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 4 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 2-3 1920 to 2-4 1920, that I last saw him alive on 2-4 1920, and that death occured on the date stated above, at 6:30 A M.
The CAUSE OF DEATH* was as follows:
Broncho-pneumonia
(Duration) — Yrs. — mos. 2 ds.
Contributory (Secondary) Influenza
(Duration — yrs. — mos. 7 ds.
(Signed) G. S. Mc Fadden M. D.
2/7 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Caldwell — DATE OF BURIAL: 2-1 1920
20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STRS. 24658

McFadden)

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 28426
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lettie Garrison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Aug 1 1867 (Month) (Day) (Year)

7. AGE: 53 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred Garrison
(Address) Nampa Ida.

15. Filed Jan 31 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 24th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1920, to Jan 24 1920, that I last saw her alive on Jan 23rd 1920, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary oedema
Acute result of
Chronic Interstitial Nephritis
8 dys (Duration) Yrs. ..... mos. ..... ds.
Contributory (Secondary) Interstitial Nephritis
(Duration Several yrs) mos. ..... ds.
(Signed) Geo. R. Proctor M. D.
19..... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL 191.....

20. UNDERTAKER: Fred K Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

Proctor

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
~~BOARD~~ OF HEALTH
Bureau of Vital Statistics

File No. 28427

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of .....

Registration District No. 17

Primary Registration District No. 2006

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Siegel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 27 (Day) 1855 (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Switzerland

10. NAME OF FATHER Chas Siegel

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Pearl Siegel

(Address) Nampa Ida

15. Filed Jan 31 1920 Pearl Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1918, to Jan 23 1920, that I last saw him alive on Jan 23 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of bowel.

(Duration) ..... Yrs. 18 mos. ✓ ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J B Smith M. D.

1-31 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 1/26 1920

20. UNDERTAKER: J.K. Robinson — ADDRESS: Nampa

Smith

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 28428
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. Sugar Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hank W. Lock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Nov (Month) 9 (Day) 1880 (Year)

7. AGE
39 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Oregon

10. NAME OF FATHER: W. H. Lock

11. BIRTHPLACE OF FATHER
(State or Country) Kansas

12. MAIDEN NAME OF MOTHER: Nettie Branch

13. BIRTHPLACE OF MOTHER
(State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. W. Lock
(Address) Emmett Ida

15.
Filed Jan 31 1920 Pearle Dodds
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 - 1920 to Jan 22 - 1920, that I last saw him alive on Jan 22 - 1920, and that death occured on the date stated above, at 11:30 M.

The CAUSE OF DEATH* was as follows:
Influenza
.....
.....
(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
.....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. P. Smith M. D.
1-27 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerstown Cem	1-25 1920
20. UNDERTAKER	ADDRESS
F. K. Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Smith

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 28429
Registered No. 102

1. PLACE OF DEATH
County of Ada
City of Boise (No. 435 W. S. Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Levi A. Pease
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Aug 2 (Month) (Day) 1858 (Year)

7. AGE: 59 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: William H Pease

11. BIRTHPLACE OF FATHER (State or Country): Vermont.

12. MAIDEN NAME OF MOTHER: Letitia Dowell

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L. G. Pease
(Address) .....

15. Filed Mar 1 1920 L. P. Gunn Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920, to Feb 28 1920, that I last saw him alive on Feb 28 1920, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Cerebral Congestion.

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) T. M. Bratton M. D.

Mar 1 1920 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Mar 2 1920

20. UNDERTAKER: Summers & Kebs. — ADDRESS: Boise Idaho

FORM V. S. No. 5-A—25 M. 1-19.

Copy

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 28439
Registered No. 102

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 430 W. S. Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse A. Pease

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Married (Write the word.)

6. DATE OF BIRTH: Aug 2 (Month) 1860 (Day) (Year)

7. AGE: 59 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: William H. Pease

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Letitia Howell

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. A. Pease
(Address)

15. Filed Mar 1 1920 — J. P. Perriman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 28 (Day) 1920 (Year)
Oct. 14

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920 to Feb 28 1920
that I last saw h. ive alive on Feb. 28 1920,
and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary): Cerebral congestion
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. M. Braxton M. D.
Mar 1 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Mar. 2 1920
20. UNDERTAKER	**ADDRESS**
Summers & Peebles	Boise Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28430

Registered No. 28430

1. PLACE OF DEATH.

County of Canyon

City of .....

(No. ....., ... St.)

Registration District No. 7

Primary Registration District No. 1006

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachael Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 16 (Day) 1877 (Year)

7. AGE: 43 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Salt Lake Utah

10. NAME OF FATHER: Jas. Terry

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Mitchell

(Address) Nampa Ida

15. Filed Jan 31 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1916, to Jan 26 1920, that I last saw her alive on Jan 26 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 5 Yrs. — mos. — ds.

Contributory (Secondary) Edema of lungs

(Duration ..... yrs. ..... mos. 3 ds.

(Signed) Geo W Chilton M. D.

19..... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 1/28 1920

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS & YORK CO., PTRS. & BDRS. 24653

Chilton

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 28431
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. 12 Th ave St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Hemm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Oct (Month) 18 (Day) 1869 (Year)

7. AGE: 50 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Dan C Goodard

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O A Hemm
(Address) Nampa Ida

15. Filed Jan 31 1920 Pearle Dodds Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1920, to Jan 24 1920, that I last saw her alive on Jan 24 1920 and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Acute Dilitation of Heart
4 hours
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Asthma
Acute Bronchitis 4
(Duration 2 yrs. — mos. — ds.
(Signed) Leo McClinton M. D.
19 ..... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 1/27 1920

20. UNDERTAKER: F. K. Robertson — ADDRESS: Nampa

Chelon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28432

Registered No. .....

Registration District No. 7

Primary Registration District No. 2006

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry D Burnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Apr (Day) 10 (Year) 188[illegible]

7. AGE: 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: David Burnett

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Dills

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs H D Burnett

(Address) Nampa Ida R.D.

15. Filed Jan 31 1920 Earle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 14 1919, to Jan. 16 1920, that I last saw h.im alive on Jan. 16 1920, and that death occured on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

1 Pulmonary tuberculosis

.....

.....

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo. D. DuKellogg M. D.

19..... (Address) Nampa Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 1/18 1920

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28433

Registered No. .....

Registration District No. 7

Primary Registration District No. 1006

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Porter Hudson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Negro

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Do not know (Month) (Day) (Year)

7. AGE: 31 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ark

10. NAME OF FATHER: Do not know

11. BIRTHPLACE OF FATHER (State or Country): Do not know

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Hilda Porter

(Address) Nampa Ida

15. Filed Jan. 19 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 8-15a M.

The CAUSE OF DEATH* was as follows:

Probably Heart failure
Fell dead in presence of
four eye witnesses.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Peckham Coroner

19..... (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida | DATE OF BURIAL: 1-15 1920

20. UNDERTAKER: F. K. Robinson | ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28434

Registered No. .....

Registration District No. 7

Primary Registration District No. 1906

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. 202 14th Ave N St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 17 (Day) 1920 (Year)

7. AGE .....Yrs.....Mos.....ds.

IF LESS than 1 day how many.....hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... /

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER E. L. Goodnight

11. BIRTHPLACE OF FATHER (State or Country) Ida

12. MAIDEN NAME OF MOTHER Grace Lyons

13. BIRTHPLACE OF MOTHER (State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. Goodnight

(Address) Nampa Ida

15. Filed Jan. 19 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth 191..., to ..... 191....., that I last saw h.....alive on ..... 191....., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Still born

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. H. Murray M. D.

1/17 1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 1/18 1920

20. UNDERTAKER: Fred L. Robinson — ADDRESS: Nampa

SYMS - YORK CO., PTRS. & ROBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 28435
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. B. Scholl

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 2 (Day) 1871 (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Conception Mo.

10. NAME OF FATHER Joseph

11. BIRTHPLACE OF FATHER (State or Country) France

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Capen
(Address) Nampa Ida

15. Filed Feb. 5 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920, to Jan 30 1920, that I last saw him alive on Jan 30 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Influenzal Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F B Smith M. D.
2/3 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Catholic Cem | DATE OF BURIAL: Feb 9 1920

20. UNDERTAKER: H. R. Robinson | ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

(Smith)

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28456

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1886

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida L. Brink

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 28 (Day) 1 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Nathaniel Beardley

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. P. Brink

(Address) Nampa Ida

15. Filed Feb. 5 1920 Pearle Dobbs, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920, to Jan 29 1920, that I last saw her alive on Jan 29 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Cardiac, dilatation.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) L P Brink M. D.

2/3 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rohrerlawn Cem — DATE OF BURIAL: Feb 3 1920

20. UNDERTAKER: F. R. Robinson — ADDRESS: Nampa.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

(Smith)

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 7006

File No. 2843

County of .....

City of ..... (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Davis Melick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. August (Month) 7 (Day) 1853 (Year)

7. AGE 64 Yrs. 6 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)... Farming own land

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Thomas W. Melick

11. BIRTHPLACE OF FATHER (State or Country) U. S.

12. MAIDEN NAME OF MOTHER Louisa (surname unknown)

13. BIRTHPLACE OF MOTHER (State or Country) U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Isaac Melick
(Address) R.F.D. 3 Caldwell Nampa Idaho

15. Filed Feb. 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 6th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-6-1920, to 2-6-1920, that I last saw h. in alive on 2-6-1920, and that death occured on the date stated above, at 1-P. M.

The CAUSE OF DEATH* was as follows:
Acute Dilitation of heart
from toxaemia

(Duration) 0 Yrs. 0 mos. 3 ds.
Contributory (Secondary) Influenza

(Duration 0 yrs. 0 mos. 10 ds.
(Signed) Geo. A. Kellogg M. D.
19..... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Robert Lawn Cem. DATE OF BURIAL 2/9 1920

20. UNDERTAKER F. P. Robinson ADDRESS Nampa

BYMS - YORK CO., PTRS. & BOKS. 24658

Dr. Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2004
Primary Registration District No. 8
File No. 28439
Registered No. 2

1. PLACE OF DEATH
County of Ada
City of Boise
(No. County Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edgar A Waters
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: ~~Unknown~~ Aug 31 1867.
(Month) (Day) (Year)

7. AGE: 52 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Hampshire

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mabel M. Whitely
(Address) Boise Idaho

15. Filed Jan 8 1920 L. P. Hummel
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 7 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1919 to Jan 7 1920
that I last saw him alive on Jan 1st 1920
and that death occurred on the date stated above, at 2 a. M.
The CAUSE OF DEATH* was as follows: Cirrhosis of the liver

(Duration) 10 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Hypocarditis
(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) M. H. Tallman M. D.
1/7 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Randolph Vermont
DATE OF BURIAL: Jan. 12 1920
20. UNDERTAKER: Summers & Kuba
ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 28440
Registered No. 3

1. PLACE OF DEATH
County of Ada
City of Boise
(No. when in Perkins Hotel)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jane Arbaugh Shawver

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Mar (Month) 31st (Day) 1850 (Year)

7. AGE: 69 Yrs. 9 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canal Dover, Ohio

10. NAME OF FATHER: Jacob Arbaugh

11. BIRTHPLACE OF FATHER: American (State or Country)

12. MAIDEN NAME OF MOTHER: Elizth Lowery

13. BIRTHPLACE OF MOTHER: American (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse Shawver
(Address) Boise Ida

15. Filed Jan 19 1920 L. O. Truman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1919 to Jan 17th 1920 that I last saw h.er alive on Jan 16 1920 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Chr. Myocarditis.

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. F. Jones & Burke M. D.
1/19 1920 (Address) 410 Overland Bldg Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 1-20 1920

20. UNDERTAKER: Schreiber & Hidenfaden | ADDRESS: Boise

St. Stewart, Printer.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28441

Registered No. 4

1. **PLACE OF DEATH**

County of Ada

City of Near Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 8

(No. 1 Mile W of Boise St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Frances Pharris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Divorced

6. DATE OF BIRTH May 21 1856
(Month) (Day) (Year)

7. AGE 63 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER James M. Pharris

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Catherine Woods

13. BIRTHPLACE OF MOTHER (State or Country) Van Buren Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Wbd Mgr I C Farmers

15. Filed Pocatello 19..... Idaho.

Local Registrar L. O. Symmes

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 16 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ saw Jan 16 1920 to ..... 19.....

that I last saw h.... alive on ..... 19.....

and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Suicide. Gunshot Wound

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner

1/19 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery | DATE OF BURIAL Jan 21 1920

20. UNDERTAKER Summers & Kirby | ADDRESS Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 20442

Registered No. 5

1. **PLACE OF DEATH**

County of Ada

City of Nas Boise

(No. 1 Mile S.W. of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vinnie Barr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Divorced

6. DATE OF BIRTH: Jan (Month) 4 (Day) 1878 (Year)

7. AGE: 42 Yrs. Mos. 12 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: William Neftzger

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Irene Young

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edgar Barr

(Address) Boise Idaho

Filed Jan 20 1920 L. D. Summers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19.... to ..... 19.....

that I last saw her alive on Jan 16 1920

and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Gun shot wound.
Murder.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner Ada Co. M.D.

Jan 20 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Jan 21 1920
20. UNDERTAKER	ADDRESS
Summers & Cobb.	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 2443
Registered No.

1. PLACE OF DEATH
County of Ada.
City of So Boise.
(No. Michigan & Belmont St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louella May Booth.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan 6 (Month) (Day) 1900 (Year)

7. AGE: Yrs. Mos. 22 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Charles Booth.

11. BIRTHPLACE OF FATHER (State or Country): Wyo.

12. MAIDEN NAME OF MOTHER: Carrie E. Jakins.

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Chas Booth.
(Address):

15. Filed Jan 29 1920 L. O. Summers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 28 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1920 to Jan 28 1920
that I last saw her alive on Jan 27 1920
and that death occurred on the date stated above, at 3 9 M.
The CAUSE OF DEATH* was as follows:
Lumpulmo.

(Duration) Yrs. mos. 4 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) R E Shurtz M. D.
Jan 28 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Jan 29 1920
20. UNDERTAKER	ADDRESS
Summers & Kelly	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Boise

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2844

Registered No. 12

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

(No. Ada County hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louie Hays

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 1818 (Day) 1 (Year)

7. AGE: 101 Yrs. 11 Mos. 15 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Duncan Johnston

(Address) Boise, Idaho.

15. Filed 1/30 1920

L. Brenau
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1919, to Jan 30 1920 that I last saw him alive on Jan 26 1920, and that death occurred on the date stated above, at 7: A. M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary) Chronic Myocarditis

(Duration) 2 yrs. mos. ds.

(Signed) T. N. Braxton M. D.

Jan 31 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ada County Cemetery

DATE OF BURIAL: Jan 31 1920

20. UNDERTAKER: Summers & Krebs

ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2845
Registered No.

1. PLACE OF DEATH
County of Ada
City of Eagle
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No.
(No. 2 Miles N.W. of Eagle St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Horace D. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 12th (Day) 1913 (Year)

7. AGE: 6 Yrs. 5 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Co, Idaho

10. NAME OF FATHER: Albert Smith

11. BIRTHPLACE OF FATHER (State or Country): Idaho. Adaco

12. MAIDEN NAME OF MOTHER: Blanch Goodall

13. BIRTHPLACE OF MOTHER (State or Country): Rooks Co. Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Smith
(Address) Eagle, Idaho

15. Filed Jan. 29, 1920 Gretchen K. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23d 1920, to Jan 28 1920
that I last saw him alive on Jan 28th 1920
and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Influenza. Broncho Pneumonia

(Duration) Yrs. mos. 6 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. L. Dutton M. D.
1/29 1920 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: 1/30 1920
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: (Boise)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28446

Registered No.

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9

Primary Registration District No.

(No. 1 mi. N W. Eagle St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alex P. Asbury.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower

6. DATE OF BIRTH: Dec 1 1846 (Month) (Day) (Year)

7. AGE: 73 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clergyman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Geo Asbury.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Sallie J. Hubanks.

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Gridlow
(Address)

15. Filed Jan. 26 1920 Frederick K. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 25 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19.....
that I last saw him alive on Jan 25 1920,
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Leakage of Heart.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers. M. D.
Jan 25 1920 (Address) Boise Ida. Canon Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Farmersburg Ind. | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Summers & Webb. | ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28449
Registered No. .....

Registration District No. 11
Primary Registration District No. 2083

1. PLACE OF DEATH.
County of Ada.
City of Meridian
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph L. Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 17 (Day) 1894 (Year)

7. AGE: 26 Yrs. ..... Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Orville Allen

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Ella Rose —

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ezella Allen
(Address) RFD No 1 - Meridian

15. Filed Jan. 26 1920 Alice A. Potter Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1920 to Jan 25 1920, that I last saw h alive on Jan 25 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Spanish Influenza
Pneumonia Typhoid

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Farview Cemetery — DATE OF BURIAL: Jan 26 1920

20. UNDERTAKER: W. Smith — ADDRESS: Meridian

MARGIN RESERVED FOR BINDING

PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28450

Registered No. .....

Registration District No. .....

Primary Registration District No. 2 0 6 2

1. PLACE OF DEATH.

County of Ada

City of Meridian (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vance W. Neal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug. (Month) 6 (Day) 1919 (Year)

7. AGE ..... Yrs. 5 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Herbert L Neal

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Edith M. Wilson

13. BIRTHPLACE OF MOTHER (State or Country) Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. L. Neal

(Address) Meridian

15. Filed Jan. 20 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1919, to Jan 18, 1920, that I last saw h[illegible] alive on Jan 18 1920, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Colitis

.....

.....

.....(Duration) ..... Yrs. ..... mos. 1 8 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Halbert F. Neal M. D.

1/[illegible] 19 20 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: Jan 20 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STATE - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 11

Primary Registration District No. 2059

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28451

Registered No.

1. PLACE OF DEATH

County of Ada

City of Meridian (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. H. Smoot

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1859 (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Vir.

10. NAME OF FATHER: Hot Stinnett

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. L. Smoot

(Address) 423 So 12th St. Boise

15.

Filed ..... 19.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 2nd (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from dau
After death - Feb. 2 1920 to .....
that I last saw ~~he~~ ..... alive on ..... 19.....,
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. L. Sutton M. D.

Feb 3 1920 (Address) Meridian, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL: 2/3 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

28452

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Boise

City of Garden Valley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12

Primary Registration District No.

(No. ....., ... St.)

File No. 2

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Helen Mills

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Jan 27 1920 Mrs. D. Evans, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920 to Jan 27 1920 that I last saw her alive on Jan 26 1920 and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia (influenza) primary (postinfluenzal)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) influenza,

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

Jan 29 1920 (Address) Garden Valley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise

DATE OF BURIAL: 19

20. UNDERTAKER

ADDRESS

Form V. S. No. 5. 10M. 6-20-11

CERTIFICATE OF DEATH

28453

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Valley
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15
Primary Registration District No.
(No. , St.)

File No.
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Thelma Holmes

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem
4. COLOR OR RACE: wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Nov (Month) 30 (Day) 1901 (Year)

7. AGE: 18 yrs. 2 mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Perry Holmes

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Nettie Callender

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W. H. Hilbun
(Address): Cabarton Ida.

15. Filed 2-11-20 191 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-7 1920, to 2-7 1920 that I last saw her alive on 2-7 1920 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
acute Congestion
2

(Duration) yrs. mos. 2 ds.
Contributory (Secondary): pneumonia
(Duration) yrs. mos. ds.
(Signed) G. E. Grozzle M. D.
2-8 1920 (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place In the
of death ..... yrs ..... mos ..... ds. State ..... yrs ..... mos ..... ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 2/10 1920

20. UNDERTAKER: C. A. Buckner
ADDRESS: Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
(No. ..... St.)

File No. 28454
Registered No. 4

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tina J Hanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. aug 4 1887 (Month) (Day) (Year)

7. AGE: 33 Yrs. 5 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ills U S A

10. NAME OF FATHER: James A Vail

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Rachel Westhaffer

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ralph Hanson
(Address) Shoshone Ida

15. Filed Feb 11" 1920
J L Fraser Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 9 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1920, to Feb 9 1920, that I last saw her alive on Feb 9 1920, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Influenza
(Duration ..... yrs. ..... mos. 14 ds.

(Signed) C P Jones M. D.
2/10 1920 (Address) Shoshone, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nazarine Wash
DATE OF BURIAL 191

20. UNDERTAKER: O L Brennan
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
File No. 28455
Registered No. 3

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lizzie Hansen

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan 1 1870
(Month) (Day) (Year)

7. AGE: 50 Yrs. ..... Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Confectioner
(b) General nature of industry, business, or establishment in which employed (or employer): in Laundry

9. BIRTHPLACE
(State or Country) Canada

10. NAME OF FATHER: John Hansen

11. BIRTHPLACE OF FATHER
(State or Country) Canada

12. MAIDEN NAME OF MOTHER: Mary Johnson

13. BIRTHPLACE OF MOTHER
(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Jerry Murphy
(Address) Shoshone

15. Filed January 22 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1920, to Jan 22 1920, that I last saw h[er] alive on Jan 21 1920, and that death occured on the date stated above, at 6 10 A.M.

The CAUSE OF DEATH* was as follows:
Cardiac

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pyorrhea
(Duration Since birth Yrs. ..... mos. ..... ds.

(Signed) A. L. Bell M. D.
Jan 22 1920 (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone Idaho
DATE OF BURIAL: 1-25- 1920

20. UNDERTAKER: O. J. Brennan
ADDRESS: Shoshone

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28456

Registered No. 2

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

Registration District No. 16

Primary Registration District No. 1916

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christina Hughes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Jan 4 1864 (Month) (Day) (Year)

7. AGE: 56 Yrs. ..... Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Holland

10. NAME OF FATHER: Louis Van Summern

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: no information as to maiden name

13. BIRTHPLACE OF MOTHER (State or Country): Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Theresa M. Sullivan

(Address) 798 - 2nd ave west Twin Falls Ida.

15. Filed January 22 1920

L. Auten
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 21 1920 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1920, to Jan 21 1920, that I last saw he alive on Jan 21 1920, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach & bowels

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) Cancer

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. J. Bell M. D.

1/21 1920 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone Idaho — DATE OF BURIAL: 1-22 1920

20. UNDERTAKER: O J Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28458

Registered No. 1

1. PLACE OF DEATH

County of Blaine

City of Minidoka

(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 14

Primary Registration District No. 2201

2. FULL NAME Cornelius Daly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Dec 13 1869 (Month) (Day) (Year)

7. AGE: 51 Yrs. ..... Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Patrick Daly

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Margaret Tangney

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Daly

(Address) Minidoka Idaho

15. Filed Jan. 12 1920

E. A. Ehmen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 10 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7, 1920, to Jan. 10 1920 that I last saw h.. alive on Jan 10 1920 and that death occurred on the date stated above, at 9 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis

Pneumonia

(Duration) 8 Yrs. ..... mos. 5 ds.

Contributory (Secondary) Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) J B Kenagy M. D.

1/12 1920 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Michigan — DATE OF BURIAL: Jan 15 1920

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2013
File No. 28459
Registered No. 2

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada W. Brock
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH
Mar (Month) 27 (Day) 1860 (Year)

7. AGE
59 Yrs. 9 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Wife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Massachusetts

10. NAME OF FATHER John B. Lake

11. BIRTHPLACE OF FATHER (State or Country) Massa

12. MAIDEN NAME OF MOTHER Emelia Norwood

13. BIRTHPLACE OF MOTHER (State or Country) Massa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Brock
(Address) Rupert Idaho

15. Filed Jan 12 1920 Ethel Elmore Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1911, to 1920 that I last saw h[illegible] alive on 1919, and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows: Auricular fibrillation
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. B. Kinney M. D.
1/12 1920 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rupert Cemetery
DATE OF BURIAL Jan 2 1920

20. UNDERTAKER W. A. Goodman
ADDRESS Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28400

Registered No. 5

1. **PLACE OF DEATH**

Registration District No. 17

Primary Registration District No. 2015

County of Minidoka

City of Rupert (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Bean

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White.	Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 20 (Day) 1887 (Year)

7. AGE: 32 Yrs. 11 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Janitor for school
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: O. F. Bean

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Ellen McCumber

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ella Bean
(Address) Rupert Idaho

15. Filed Jan 5 1920 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~January~~ December (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19 1920, to Dec. 31 1920, that I last saw h~~im~~ alive on Dec 31 1920, and that death occurred on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal meningitis
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. H. Elmore M. D.
1-2 1920. (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetary — DATE OF BURIAL: Jan 2 1920

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28463

Registered No. 6

1. PLACE OF DEATH

County of Minidoka

City of Rupert (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irma Hymas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Child

6. DATE OF BIRTH: Jan (Month) 16 (Day) 1913 (Year)

7. AGE: 7 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Arthur J Hymas

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Cordelia Davis

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur J Hymas
(Address) Rupert Idaho

15. Filed Feb 4 1920 E. T. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26th 1920 to Jan 31st 1920 that I last saw h.r. alive on Jan 31st 1920 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Broncho Pneumonia, bilateral

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Leland Frazier M. D.

19..... (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Acequia Cemet	Feb 4 1920
20. UNDERTAKER	**ADDRESS**
W. A. Goodman	Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 14

Primary Registration District No. 2013

(No. ..... , ... St.)

File No. 28464

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Karl L Simpson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov (Month) 10 (Day) 1917 (Year)

7. AGE: 2 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Roy Simpson

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Bavia Smith

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Simpson

(Address) Rupert Idaho

15. Filed Feb 4 1920 W. A. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to Jan 11 1920 that I last saw h[illegible] alive on Jan 10 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebro-Spinal Meningitis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Influenza ?

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) W. A. Elmore M. D.

2-7 1920 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Jan 13 1920
20. UNDERTAKER	ADDRESS
W. G. Goodman	Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

(No. ..... St.)

Registration District No. 11

Primary Registration District No. 1015

File No. 28465

Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant of Roy Fife

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
	White	Infant

6. DATE OF BIRTH: Jan (Month) 16 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 10 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Roy Fife

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Minnie Walton

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jess Walton
(Address) Burley Idaho

15. Filed Jan 19 19.. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Premature

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

1 19.. (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Jan 17 1920
20. UNDERTAKER	ADDRESS
W. G. Goodman	Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 28466
Registered No. 9

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tabitha O Kirk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (write the word)

6. DATE OF BIRTH: Oct (Month) 21 (Day) 1857 (Year)

7. AGE: 62 Yrs. 3 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: John Stewart

11. BIRTHPLACE OF FATHER (State or Country): Alabama

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Della Carmean
(Address) Rupert Idaho

15. Filed 2-4 1920 E. E. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Jan 30 1920, that I last saw her alive on Jan 29 1920 and that death occurred on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos., 5 ds.
Contributory (Secondary) Chronic Bronchitis
(Duration) 20 yrs. ..... mos. ..... ds.

(Signed) E. E. Elmore M. D.
2-4 1920 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemetery — DATE OF BURIAL: Feb 2 1920

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28467

Registered No. 16

Registration District No. 17

Primary Registration District No. 13

1. PLACE OF DEATH

County of Minidoka

City of Rupert (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Morgan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word) Married

6. DATE OF BIRTH: July (Month) 31 (Day) 1905 (Year)

7. AGE: 14 Yrs. 5 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Girl
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: A. C. Morgan

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Estella Holt

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A C Morgan
(Address) Rupert R. R. 4

15. Filed Jan 26 1920 E. T. [illegible], Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920 to Jan 26 1920 that I last saw h— alive on Jan 20 1920 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Jan 26 1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn Cemetery

DATE OF BURIAL: Jan 26 1920

20. UNDERTAKER: W. G. Goodman

ADDRESS: Rupert Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Minidoka — Registration District No. 14

City of Rupert — Primary Registration District No. 2 15

(No. ..... , ... St.)

File No. 28468

Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Bridget Marie Ridy Pettit

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Fem

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Married

6. **DATE OF BIRTH**: Nov (Month) 6 (Day) 1886 (Year)

7. **AGE**: 33 Yrs. 2 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Pennsylvania

10. **NAME OF FATHER**: Coleman P Ridge

11. **BIRTHPLACE OF FATHER** (State or Country): Kentucky

12. **MAIDEN NAME OF MOTHER**: Mary King

13. **BIRTHPLACE OF MOTHER** (State or Country): West Virginia

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Agnes Trathen

(Address) Rupert Idaho

15. Filed 2 7 19 20 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Jan (Month) 22 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Jan 15 1920 to Jan 22 1920 that I last saw h-- alive on Jan 22 1920 and that death occurred on the date stated above, at 10 A. M.

The **CAUSE OF DEATH*** was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

2-7 1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Burley Cemetery — **DATE OF BURIAL**: Jan 24 1920

20. **UNDERTAKER**: W. A. Gardeman — **ADDRESS**: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2013
File No. 28469
Registered No. 12

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Corwin Stone
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 13 (Day) 1919 (Year)

7. AGE: 5 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Vern Stone

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Alva Baily

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Raphael Bailey
(Address) Rupert Idaho

15. Filed 2 4 19 20 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920 to Jan 27 1920 that I last saw him alive on Jan 27 1920 and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
2-27 1920 (Address) Rupert Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Jan 27 1920

20. UNDERTAKER: W. G. Gudmun — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 14
Primary Registration District No. 2015
File No. 28470
Registered No. 13

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Iris Noble
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Sept (Month) 24 (Day) 1906 (Year)

7. AGE: 13 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Munroe C Noble

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jannett L. Hellewell

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary A Hellewell
(Address) Heyburn Idaho

15. Filed Feb 9 1920
E H Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Jan 29 1920
that I last saw her alive on Jan 29 1920
and that death occurred on the date stated above, at 9 9 M.
The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bronchopneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J B Kennaugh M. D.
2/10 1920 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: W. C. Goodman
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 74
Primary Registration District No. 2010

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28471
Registered No. 14

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Lore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: June (Month) 11 (Day) 1844 (Year)

7. AGE: 75 Yrs. 6 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Plaster
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Henry Lore

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Guy Shillington
(Address) Rupert Idaho

15. Filed Feb. 9 1920 E H Eharpe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) [redacted] (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to Jan 8 1920, that I last saw h[redacted] alive on Jan 8 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kennedy M. D.

1/10 1920 (Address) [redacted] Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery
DATE OF BURIAL: Jan 10 1920

20. UNDERTAKER: W. A. Goodman
ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 28472
Registered No. 15

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph W. Noble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Child

6. DATE OF BIRTH: Jan (Month) 14 (Day) 1909 (Year)

7. AGE: 11 Yrs. ..... Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. S. Noble

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jennette Hellewell

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mary A Hellewell
(Address): Heyburn Idaho

15. Filed Feb 10 1920 — E. A. Elmore, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Jan 29 1920, that I last saw h[illegible] alive on Jan 29 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Bronchopneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kenney M. D.

2/10 1920 (Address) J B Kenney

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Feb 2 1920

20. UNDERTAKER: W. G. Gardner — ADDRESS: Rupert

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 3017
File No. 28473
Registered No. 16

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennette L. Noble
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: July (Month) 22 (Day) 1885 (Year)

7. AGE: 35 Yrs. 7 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Geo. E. Hellowell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary A Burrup

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary A. Hellowell
(Address) Heyburn Idaho

15. Filed Feb. 10 1920 — E W Ekman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Jan 29 1920, that I last saw h.. alive on Jan 29 1920, and that death occurred on the date stated above, at ~ M.

The CAUSE OF DEATH* was as follows:
Influenza
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Bronchopneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B K..... M. D.
2/10 1920 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Feb 2 1920

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1017-2017
File No. 28474
Registered No.

1. PLACE OF DEATH
County of Jerome
City of Ft. M. S. H.
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lloyd B Webster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: July (Month) 8 (Day) 1886 (Year)

7. AGE: 33 Yrs. 6 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: Chas. Webster

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Sallie Easterly

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John B Webster
(Address) Jerome

15. Filed Jan 17 1920 E. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1920 to Jan 16 1920
that I last saw h. alive on Jan 16 1920
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows: Fracture Base of Skull and other injuries acct. of being accidently Caught in Clutch and Flywheel of Engine.
(Duration) ..... Yrs. ..... mos. 2 1/2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. D. Piper M. D.
1/17 1920 (Address) Jerome

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome — DATE OF BURIAL: Record 1/17 1920

20. UNDERTAKER: H. A. Harrison — ADDRESS: Jerome Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28478

Registered No. 3

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1050

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maud V. Acker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 24 (Day) 1872 (Year)

7. AGE: 47 Yrs. 5 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New Zealand

10. NAME OF FATHER: Wm Smith

11. BIRTHPLACE OF FATHER (State or Country): N. Z.

12. MAIDEN NAME OF MOTHER: Emma Sheldon

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Floyd J. Acker
(Address) Coeur d'Alene

15. Filed Jan. 21 1920 Gus Nelson, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 16 1920, to Jan 19 1920, that I last saw h[illegible] alive on Jan 17 1920, and that death occured on the date stated above, at 5:00 P. M.

The CAUSE OF DEATH* was as follows:
Recurrent Carcinoma
following operation

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. K. Hedrick M. D.
1/21 1920 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Spokane. Wn — DATE OF BURIAL: Jan 22 1920

20. UNDERTAKER: C. Casady — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STRS. 24053

Form V. S. No. 1-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 28479
Registered No. 2

1. PLACE OF DEATH.
County of Kootenai
City of Coeur D'Alene (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christian Martin Bielke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PENCIL WILL NOT BE ACCEPTED. Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If child is less than one day old, state number of HOURS or MINUTES. NAME should be stated in full—surname (family name) last. If death occurred in a hospital, institution or camp, the NAME instead of the street and number should be given. If death occurs away from usual residence, give facts called for under special information. If death occurred from violence, state MEANS OF INJURY, whether ACCIDENTAL, SUICIDAL or HOMICIDAL. Industry, business, or establishment in which employed (or employer) should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item of information should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. If child is less than one day old, state number of HOURS or MINUTES. NAME should be stated in full—surname (family name) last. If death occurred in a hospital, institution or camp, the NAME instead of the street and number should be given. If death occurs away from usual residence, give facts called for under special information. If death occurred from violence, state MEANS OF INJURY, whether ACCIDENTAL, SUICIDAL or HOMICIDAL. Industry, business, or establishment in which employed (or employer) should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Name of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Jan (Month) 2 (Day) 1867 (Year)
7. AGE: 53 Yrs. 4 Mos. 5 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Telegrapher
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: Ferdinand Bielke
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Anna Kirchenberg
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Eva A Bielke
(Address): Coeur d'Alene Ida
15. Filed Jan 9 1920 Geo Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 7 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 1917, to Jan. 7. 1920, that I last saw h[illegible] alive on Jan. 3. 1920, and that death occured on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John O Lemon M. D.
Jan 8 1920 (Address) Coeur d'Alene - Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where, was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary — DATE OF BURIAL: Jan 9 1920
20. UNDERTAKER: C Cassedy — ADDRESS: Coeur d'Alene

Form 1-25 M. 1-16-13

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF D[redacted]

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2072
File No. 28480
Registered No. 54

1. PLACE OF DEATH.
County of Power
City of Amer. Falls (No. Bethany Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Angie Hinckley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: June (Month) 15 (Day) 1891 (Year)

7. AGE: 28 yrs. 7 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: S. V. Hall

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Elizabeth Newson

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. V. Hall
(Address) American Falls. Ida

15.
Filed 1/20 1920 R. F. Nolte
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
1 (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9th 191[illegible], to Jan 15th 1920
that I last saw h[illegible] alive on [illegible] 1920
and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
General Peritonitis probably caused by a ruptured Appendix
(Duration) yrs. mos. 8 1/2 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Richard F. Nolte M. D.
1-15 1920 (Address) American Falls. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: American Falls Ida
DATE OF BURIAL: Jan. 16 1920

20. UNDERTAKER: N. R. Hager
ADDRESS: Amer. Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

28481

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2
Registered No. 88

Registration District No. 25
Primary Registration District No. 2072

1. PLACE OF DEATH
County of Power
City of Am Falls
If death occurs away from usual residence, give facts called for under special information.

(No. 13 Attleny Hospital St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Elizabeth D. Hatton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Female	White	Married

6. DATE OF BIRTH. April 11 1896
(Month) (Day) (Year)

7. AGE 23 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER C. L. Burkee

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Alice C. Miracle

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Burkee
(Address) Am Falls

15. Filed 1/30 1920. R. F. Nath Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 10 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1920 to Jan 10 1920
that I last saw her alive on Jan 10 1920
and that death occurred on the date stated above, at 1145 A.M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) C. F. Deliver M. D.
1/12 1920. (Address) Am Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Am. Falls. Ida
DATE OF BURIAL 1/12 1920

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

28482

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

Primary Registration District No. 2072

File No. 2

County of Power

City of ..... (No. ....., ... St.)

Registered No. 82

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Poulsen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1 (Month) 2 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 15 mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edward H. Poulsen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rettie Sorensen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward H. Poulsen
(Address) American Falls, Id.

15.
Filed 1/4 1920 R. T. Nott
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 2 1920 to Jan. 2 1920 that I last saw h[illegible] alive on Jan 2 1920 and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:

Atelectasis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Richard T. Nott M. D.

1/2 1920 (Address) American Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Neeley Idaho

DATE OF BURIAL: 1 – 3 1920

20. UNDERTAKER: None

ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 2119
File No. 28484
Registered No. 1

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rudolph Holla Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 15 (Day) 1905 (Year)

7. AGE: 14 Yrs. 5 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Preston Franklin Co Idaho

10. NAME OF FATHER: Lorn C. Miller

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Emma Holla

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gina Miller
(Address) Preston Idaho

15. Filed Feb. 6 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27, 1919, to January 2 1920
that I last saw him alive on Jan 2 1920
and that death occurred on the date stated above, at 5:15 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia
Bronchial

(Duration) 1 Yrs. 1 mos. 6 ds.
Contributory (Secondary) Septicaemia
(Duration) 1 yrs. 1 mos. 12 ds.

(Signed) G. W. State M. D.
Jan 4 1920 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28485
Registered No. 2

1. PLACE OF DEATH
County of Franklin
City of Weston
(No. ..... St.)
Registration District No. 2-7
Primary Registration District No. 2-7-9
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Edwar Kirtchell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH May (Month) 9 (Day) 1855 (Year)

7. AGE 34 Yrs. 8 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Charles Edward Kirtchell Sr.

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER ~~Elizabeth~~ Fannie Seamons ~~Gibson~~

13. BIRTHPLACE OF MOTHER (State or Country) England. ~~Idaho~~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Luther Kirtchell
(Address) Weston, Idaho

15. Filed Jan 16 1920 D. A. Cullen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1917, to Dec 14th 1920 that I last saw h[illegible] alive on July 8 1919, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of Face

Duration ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Holder M. D.
19..... (Address) Weston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Beaver Dam, Utah

19. PLACE OF BURIAL OR REMOVAL Beaver Dam, Utah — DATE OF BURIAL Jan 17 1920

20. UNDERTAKER [illegible] — ADDRESS Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Mr. Bland.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28486

Registered No. 5

1. PLACE OF DEATH

County of Franklin

City of Clayton

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

2. FULL NAME Martha Caroline Bess

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: July (Month) 19 (Day) 1843 (Year)

7. AGE: 76 Yrs. 6 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Nels Hansen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Elizabeth Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Wally

(Address) Clayton Idaho

15. Filed Feb 8 1920 Dr. E. R. Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1920, to Jan 27 1920, that I last saw h.. alive on Jan 27 1920, and that death occurred on the date stated above, at 10P. M.

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis

.....

.....

.....(Duration) — Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Hart M. D.

1/29/1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clayton, Idaho DATE OF BURIAL: Jan. 31 1920

20. UNDERTAKER: G. F. Lundquist ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Mr. Cutler Jr.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

28467

1. PLACE OF DEATH

County of Franklin

City of Preston

Registration District No. 27

Primary Registration District No. 2119

(No. ..... St.)

File No. .....

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nathan Emory Belnap

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan. (Month) 8 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Preston

10. NAME OF FATHER: Emory Belnap

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Martha Kershaw

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emory Belnap Jr.

(Address) Preston

15.

Filed Jan 27 1920 D. A. Cutler

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920 to Jan 26 1920 that I last saw h.im alive on Jan 26 1920, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH was as follows:

Bronchio Pneumonia

.....

.....

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. A. Cutler M. D.

19..... (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: Jan 28 1920

20. UNDERTAKER: C. C. Lundquist — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2719
File No. 28488
Registered No. 8

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Wilson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 11 (Day) 1871 (Year)

7. AGE: 48 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Wm Wilson

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Elizabeth Adams

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James A Dixon
(Address) Portland Oregon

15.
Filed Jan 26 1920 D. W. Rulon
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1920 to Jan 21 1920 that I last saw h.im alive on Jan 21 1920 and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia
.....(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) none
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Dr R A Campbell M. D.
Jan 23 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thunder Wood, Colo. DATE OF BURIAL: Jan 23 1920

20. UNDERTAKER: T. C. Lundgren ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28489

Registered No. 3

1. PLACE OF DEATH

County of Shoshone

City of Clarkia

(No. ....., ... St.)

Registration District No. 22

Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Amanda Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 9 (Day) 1879 (Year)

7. AGE: 40 Yrs. 7 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: P. J. Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mary Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. T. Roberts

(Address) Clarkia

15. Filed Jan 24 1920

H E Hyatt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920, to Jan 23 1920, that I last saw her alive on Jan 21 1920, and that death occurred on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. 8 ds.

(Signed) W P Platt M. D.

Jan 24 1920 (Address) St Maries Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Maries

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Hunt Co.

ADDRESS St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28490

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 22

Primary Registration District No. 2049

County of Bonneville

City of Ucon (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Gillis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. not known
January 18th 1920
(Month) (Day) (Year)

7. AGE apparently
55 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)... timber worker

9. BIRTHPLACE (State or Country) not known

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E M Stone
(Address) Dayton Idaho

15.
Filed Jan 23 1920. H E Hunt Local Registrar

SYMS-YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan 18 1920
(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1920, to Jan 18 1920, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Paralysis agitans
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Complications
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A Adcock - Coroner M. D.
1/20 1920 (Address) St Maries, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Verdlawn — DATE OF BURIAL Jan 23 1920

20. UNDERTAKER Mitchell & Meagher — ADDRESS St. Maries

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

55101

1. PLACE OF DEATH

County of Benewah

City of St Maries

(No. ....., ... St.)

Registration District No. 32

Primary Registration District No. 2049

File No. .....

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee L. Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 18 (Day) 1854 (Year)

7. AGE: 66 Yrs. 7 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lee L Martin

(Address) St Maries

15. Filed Jan 5 1920

H Eastman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1919, to Jan 4 1920, that I last saw h[illegible] alive on Jan 4 1920, and that death occurred on the date stated above, at 6[illegible] M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemmorrhage.

..... (Duration) ..... Yrs. 1 mos. 4 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Owen D. Platt M. D.

Jan 5 1920 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	1-6 1920
20. UNDERTAKER	ADDRESS
H Eastman Co.	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 28492
Registered No. 0

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Bennett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: July (Month) 19 (Day) 1919 (Year)

7. AGE: Yrs. 6 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mtn Home Ida

10. NAME OF FATHER: A. L. Bennett

11. BIRTHPLACE OF FATHER (State or Country): Jones Mills Penn.

12. MAIDEN NAME OF MOTHER: Mabel Carter

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Bennett
(Address) Mtn Home Ida

15. Filed Jan. 29th 1920 W. W. Mather Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1920 to Jan 28 1920 that I last saw her alive on Jan 28 1920 and that death occurred on the date stated above, at 6.30 P. M.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Evans M. D.
1-29-1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Ida | DATE OF BURIAL: Jan. 30 1920

20. UNDERTAKER: C. W. Conover | ADDRESS: Mtn Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 54
Primary Registration District No. 20
(No. ....., ... St.)

File No. 28493
Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Elmore
City of Mtn Home

If death occurs away from usual residence, give information called for under special information.

2. FULL NAME Infant of Mrs J. M. Cheney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 5 (Day) 1920 (Year)

7. AGE: ....Yrs....Mos. 3 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mtn Home Ida

10. NAME OF FATHER J. M. Cheney

11. BIRTHPLACE OF FATHER (State or Country) Bannack City Montana

12. MAIDEN NAME OF MOTHER Alice Lahaie

13. BIRTHPLACE OF MOTHER (State or Country) North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. M. Cheney
(Address) Mtn Home Ida

15. Filed Jan 9th 1920 W. O. Walker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to Jan 8 1920, that I last saw her alive on Jan 8 1920, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

.....(Duration) .....Yrs. .....mos. 3 ds.

Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.

(Signed) L. E. Edwards M. D.
1-10 1920 (Address) Mtn Home Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Cem. DATE OF BURIAL: 1-9 1920

20. UNDERTAKER: A. W. Conover ADDRESS: Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 2020
File No. 28494
Registered No. 2

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. M. Goad
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: unknown (Month) (Day) (Year)

7. AGE: 37 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher and Stock-
(b) General nature of industry, business or establishment in which employed (or employer): man of Richfield, Ida.

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Easton
(Address) Mtn Home, Ida.

15. Filed Jan. 12th 1920 — R. W. Walker, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental — by Run ruck caused by negligence of Conductor & brakeman
Sudden
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Easton Coroner M. D.
1/11 1920 (Address) Mtn Home, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Richfield Ida — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: A. W. Conover — ADDRESS: Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 28496
Registered No. 5

1. PLACE OF DEATH
County of Elmore
City of Mtn. Home
(No. 57 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Mellen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 7th (Day) 1851 (Year)

7. AGE: 69 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cornwall England

10. NAME OF FATHER: Jas. Mellen

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Rosevear

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jane E. Mellen
(Address) Mtn Home Ida

15. Filed Jan. 18th 1920 Lew. Walther Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 17 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-16-1920, to 1-17-1920 that I last saw h.m alive on 1-17-1920, and that death occurred on the date stated above, at 5 00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 25 Yrs. mos. ds.

Contributory (Secondary) Hypertrophy of Heart

(Duration) yrs. mos. ds.

(Signed) J. E. Evans M. D.

1-21-1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home — DATE OF BURIAL: 1-21 1920

20. UNDERTAKER: A. W. Conover — ADDRESS: Mtn Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 28497
Registered No. 5

1. PLACE OF DEATH
County of Elmore
City of Mountain Home (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvin Newton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 2 (Day) 1847 (Year)

7. AGE: 72 Yrs. 11 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shoe Maker
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Allegahney Co Penn

10. NAME OF FATHER: Myers Newton

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred R. Price
(Address) Mtn Home

15. Filed Jan. 16th 1920 — Lew Mather, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2 1919, to Jan. 16 1920 that I last saw h[illegible] alive on Jan 15 1920 and that death occurred on the date stated above, at 10.00 M.
The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(Duration) 20 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Mitral stenosis 1 Year
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Evans M. D.
1-26-1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mtn. Home Ida | DATE OF BURIAL: Jan 17 1920

20. UNDERTAKER: A. W. Conover | ADDRESS: Mtn Home Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 54
Primary Registration District No. 2020
File No. 28498
Registered No. 1

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Powell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: unknown (Month) (Day) (Year)

7. AGE: 15 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter Powell

11. BIRTHPLACE OF FATHER (State or Country): Albion, Ida.

12. MAIDEN NAME OF MOTHER: Hattie Winterburn

13. BIRTHPLACE OF MOTHER (State or Country): Albion Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. W. Conover
(Address) Mtn Home

15. Filed June 12th 1920 B. W. Luther Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 11th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
accidental — by fly rock caused by negligence of Contractor + blasting
..... (Duration) Instaneous Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. W. Conover M. D.
1/12 1920 (Address) Mtn Home Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Idaho
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: A. W. Conover
ADDRESS Mtn. Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

No. 5-25 Form 56-12

CERTIFICATE OF DEATH. 28500

STATE OF KANSAS
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 33

County of Bear Lake

Primary Registration District No. 2132

File No. 26

City of Paris (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl Jane Grimes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug. 5th, (Month) (Day) 1898 (Year)

7. AGE: 21 Yrs. 5 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: James M. Dobbs

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: S. Moss.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles E. Grimes

(Address) Paris Idaho

15. Filed 2/10 1920 R. J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920 to Feb 1 1920, that I last saw her alive on Feb 1 1920 and that death occured on the date stated above, at 4 45 P.M.

The CAUSE OF DEATH* was as follows:

Edema of glottes, complicated with Exophthalmic goiter & Pregnancy

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Exophthalmic goiter Pregnancy

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Moore M. D.

2/2/20 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 3 mos. 11 days. In the State ..... yrs. 6 mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Anderson Missouri

19. PLACE OF BURIAL OR REMOVAL: Anderson Missouri — DATE OF BURIAL: ..... 191.....

20. UNDERTAKER: Tolly Williams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMB - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-19.

28501

CERTIFICATE OF [illegible]ATH

State of [illegible]
BOARD OF [illegible]
Bureau of Vital Stat[illegible]

Registration District No. 3

Primary Registration District No. 2132

File No. 97

Registered No.

1. PLACE OF DEATH

County of Bear Lake.

City of Bloomington (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Tomer Findley.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1920 (Year)

7. AGE: ....Yrs....Mos....ds.

IF LESS than 1 day how many 10 hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: baby —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bloomington

10. NAME OF FATHER: Ralph Findley

11. BIRTHPLACE OF FATHER (State or Country): Bloomington

12. MAIDEN NAME OF MOTHER: Lillian Tomer

13. BIRTHPLACE OF MOTHER (State or Country): Garden City Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Findlay

(Address) Bloomington

15. Filed 2/10 1920

R. J. Sutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1920 to Jan 17 1920 that I last saw him alive on Jan 17 1920 and that death occurred on the date stated above, at 4-05 P.M.

The CAUSE OF DEATH* was as follows:

Premature (6 mo)

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) R. J. Sutton M. D.

Jan 17 1920 (Address) Paris Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bloomington — DATE OF BURIAL: 1/18/20

20. UNDERTAKER: No. — ADDRESS: —

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-45 M. 3-16-18

CERTIFICATE OF DEATH. 28502

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Paris
Registration District No.
Primary Registration District No.
(No. , St.)
File No. 98
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Minson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. July (Month) 26 (Day) 1841 (Year)
7. AGE: 78 Yrs. 5 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: John Minson
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Ann Baker
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David Minson
(Address) Paris Idaho
15.
Filed 9/10 1921
R. J. Sutton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1920 to Jan 15 1920, that I last saw h VM alive on Jan 14 1920 and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:
Chr. Int. Nephritis

(Duration) 5 Yrs. mos. ds.
Contributory (Secondary) General Debility
(Duration yrs. mos. ds.
(Signed) E. O. Mowry M. D.
Jan 16 1920 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs..mos..days In the State ..yrs..mos..days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris
DATE OF BURIAL 191

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRD - YORK CO., PTRS. & STNRS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 28503

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 33

Primary Registration District No. 7192

File No. 99

County of Bear Lake

City of Paris Idaho (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug 4 1840 (Month) (Day) (Year)

7. AGE: 79 Yrs. 5 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): London England

10. NAME OF FATHER: George

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Mary Raby

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) X Edward R Davis
(Address) Paris Idaho

15.
Filed ..... 191.....
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920 to Feb 7 1920, that I last saw h.. alive on Feb 1 1920 and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
General Debelity
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Neurits, Brachial, left
.....(Duration ..... yrs. 1 mos. ..... ds.
(Signed) O Moore M. D.
2-9 1920 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Ida — DATE OF BURIAL: 2/12 1920

20. UNDERTAKER: Bishop Town — ADDRESS: Pari

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28505
Registered No. 1

1. PLACE OF DEATH
County of Twin Falls
City of Hansen Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36
Primary Registration District No. .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bird Turner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Jan 10 (Month) (Day) 1886 (Year)

7. AGE 34 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ark

10. NAME OF FATHER: J A Cole

11. BIRTHPLACE OF FATHER (State or Country): Ark

12. MAIDEN NAME OF MOTHER: Mary Kell

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Jan 10 1920 J M Davis Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 10 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920 to Jan 10 1920
that I last saw her alive on Jan 9 1920
and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Pr Pneumonia Tuberculosis

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pregnancy & Miscarriage

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J M Davis M. D.
Jan 10 1920. (Address) Kimberly Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 1-11 1920

20. UNDERTAKER: J E Ewert — ADDRESS: Twin Falls

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085
(No. ....., ... St.)

File No. 28506
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gilbert Gulick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct (Month) 9 (Day) 1839 (Year)

7. AGE: 80 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many .... hrs. or .... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Stephen Gulick

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Nancy Gilland

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mary Gulick
(Address): Filer, Ida.

15. Filed Jan 27 1920 John F. Cavanaugh Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20. 1920 to Jan. 26 1920
that I last saw him alive on Jan. 20 1920
and that death occurred on the date stated above, at 10:47 A.M.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary) Carcinoma of neck & Life

(Duration) 3 Yrs. mos. ds.

(Signed) Frank A. Dwight M. D.
Jan 26 1920 (Address) Filer Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days, In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Cemetery — DATE OF BURIAL: Jan. 27. 1920

20. UNDERTAKER: F E Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of ....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 28507
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wally Durbin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct 20 (Month) (Day) 1854 (Year)

7. AGE: 65 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Buck Sims

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Mary J. Sullivan

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mike Simms
(Address) Roy C. Idaho

15.
Filed Jan. 3. 1920. John T. Loughlin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 8 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 26 1919 to Jan. 1 1920
that I last saw her alive on Jan. 1 1920.
and that death occurred on the date stated above, at 6:20 A.M.
The CAUSE OF DEATH* was as follows:
Irritable Heart
.....
.....
.....(Duration) .... Yrs. .... mos. 8 ds.
Contributory (Secondary) Abortion
.....(Duration) .... Yrs. .... mos. .... ds.
(Signed) C. D. Weaver M. D.
1/2 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Jan. 3 1920

20. UNDERTAKER: J. E. Wescott — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28509
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1845
(No. ....., ... St.)

2. FULL NAME Ada Ramey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Mar 30 1 (Month) (Day) (Year)

7. AGE: 9 Yrs. 9 Mos. 11 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charley Ramey

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Permelia Hurd

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Ramey
(Address) Box 202 Twin Falls

15. Filed Jan 12 1920 John F. Coughlin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 11 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920 to Jan 10 1920 that I last saw h. alive on ..... 191.... and that death occurred at the date stated above, at 2 ..... M.

The CAUSE OF DEATH* was as follows: See

Suffocation due to being caught in fire and not rescued in time

(Duration) ..... Yrs. few minutes ds.

Contributory (Secondary) Some burns not of themselves fatal.

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. C. M. Symms M. D.

19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 1-13 1920

20. UNDERTAKER: J. E. Deweese — ADDRESS: Twin Falls

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28510
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1082
(No. ....., ... St.)

2. FULL NAME Elsaira Linton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. March 21 (Month) (Day) 1839 (Year)
7. AGE 80 Yrs. 1 Mos. 17 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House maid
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: S L Cox
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Annie Reynolds
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Minnie Evans
(Address) .....
15. Filed Jan 12 1920 John F. Caughlin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 7 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1. 1919 to Jan 7 1920 that I last saw her alive on Jan 7th 1920 and that death occurred on the date stated above, at 10:15 P.M.
The CAUSE OF DEATH* was as follows:
Post operative Shock,
.....
.....
(Duration) ..... Yrs. About 10 hrs.
Contributory (Secondary) Appendicitis
(Duration) One Yrs. to my knowledge
(Signed) A Evans M. D.
Jan 10th 1920. (Address) Twin Falls Ida.
*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Jan 12 1920
20. UNDERTAKER: J E Reed — ADDRESS: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 28511
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amos Warren Blazer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: 4 (Month) 22 (Day) 1874 (Year)

7. AGE: 45 Yrs. 8 Mos. 20 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Resturant proprietor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Cornelius Blazer

11. BIRTHPLACE OF FATHER (State or Country): Paris France

12. MAIDEN NAME OF MOTHER: Matilda Belong

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Georgia Etta Blazer
(Address) Jerome Ida.

15. Filed Jan 13 1920 John F. Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12" 1920 to Jan 13 1920
that I last saw h. alive on Jan 17 1920
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH was as follows:
Unknown,

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Boyd M. D.
Jan 13 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: P J Grossman
ADDRESS: Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of ....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ...., ..., St.)

File No. 2851?

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva Elizabeth Beutler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: 12 (Month) 22 (Day) 1897 (Year)

7. AGE: 23 Yrs. .... Mos. 17 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: Charles Stuart

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Wind Beutler

(Address) 344 East Twin Falls Ida

15. Filed Jan 10 1920 John F Cavenaugh Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 7 (Month) .... (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920 to Jan 7 1920 that I last saw h.. alive on Jan 7 1920 and that death occurred on the date stated above, at .... M.

The CAUSE OF DEATH* was as follows:

Pneumonia ono sided

.... (Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary) ....

.... (Duration) .... yrs. .... mos. .... ds.

(Signed) F. S. Mason M. D.

Jan 7 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake city Utah | DATE OF BURIAL .... 19....

20. UNDERTAKER: E C Reed | ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 28513
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of (
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo W Byard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	widowed

6. DATE OF BIRTH
Sep 17 1
(Month) (Day) (Year)

7. AGE
73 Yrs. 4 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Nat Heaven

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G W Byard
(Address) Kimberly Ida

15.
Filed Jan 16 1920 John F Caughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 5106

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan 17 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1920 to Jan 17 1920
that I last saw him alive on Jan 16 1920
and that death occurred on the date stated above, at 6 25 P.M.
The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) Yrs. mos. 14 ds.
Contributory (Secondary) Senility
(Duration) yrs. mos. ds.

(Signed) J. W. Davis M. D.
1/17 1920 (Address) Kimberly Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls Idaho | DATE OF BURIAL 19

20. UNDERTAKER L. Elliott | ADDRESS Kimberly

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 085
File No. 28514
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada May Gibson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 15 (Day) 1857 (Year)

7. AGE: 62 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Andrew Morris

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ed Humphrey
(Address) Twin Falls Idaho

15. Filed Jan 22 1920 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ examined deceased from Jan. 17 1920 to ..... 19.....
that ~~I last saw h~~ alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Apparently,
Brights Disease
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. D. Weaver M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Washington — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28515
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 1085
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ben Grubb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.)
Male	white	Married

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1860 (Year)

7. AGE 59 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ver

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ..... Twin Falls
(Address) ..... Twin Falls

15. Filed Jan. 24 1920 John F. Caughlin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 23 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1920 to Jan 23 1920
that I last saw him alive on Jan 20 1920.
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Mania a potu
.....
.....
.....(Duration) ..... Yrs..... mos. 3 ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) ..... W. G. Fike M. D.
1/24/1920 (Address) ..... Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Ida — DATE OF BURIAL Jan 25 1920

20. UNDERTAKER J E Everett — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28516
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1082
(No. ....., ... St.)

2. FULL NAME Sikharus Gates

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov 24 (Month) (Day) 1832 (Year)

7. AGE: 87 Yrs. 2 Mos. 3 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Salmon Gates

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Lucy Saunders

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ernest H Gates
(Address): Twin Falls

15. Filed Feb 2 1920 John F Caughlan Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 28 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 19 to Jan 28 1920
that I last saw him alive on Jan 28th 1920
and that death occurred on the date stated above, at 11 1/2 P.M.
The CAUSE OF DEATH* was as follows:
Senility
(Duration) .... Yrs. .... mos. .... ds.
Contributory (Secondary) Oedema of Lungs
(Duration) .... Yrs. .... mos. 1 ds.
(Signed) J H Coughlan M. D.
1-30 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Jan 31 1920

20. UNDERTAKER: J E Devitt — ADDRESS: Twin Falls Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28517
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 37
Primary Registration District No. 1053
(No. ....., ... St.)

1. PLACE OF DEATH
County of Twin Falls
City of .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernice Raney

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 20 (Day) 1915 (Year)

7. AGE: 4 Yrs. 10 Mos. 9 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Inspector
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: ~~Wash~~ Charley Raney

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Rebecca Hurd

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [signature]
(Address) 6[illegible]

15. Filed Jan. 12 1920. John F. Caughlin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-10 1920 to 1-10 1920
that I last saw her alive on ~~the~~ when ..... 191....
and that death occurred ~~on the date~~ stated above, at 2 ..., ..M.

The CAUSE OF DEATH* was as follows:
Suffocation due to being caught in burning building and rescue delayed
(Duration) ..... Yrs. ..... Feb minutes ds.
Contributory (Secondary) Burns of thighs & face
(Duration) 0 Yrs. ..... mos. ..... ds.
(Signed) W. E. Cummins M. D.
1-11. 1920. (Address) 310 3rd N. Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 1-13. 1920

20. UNDERTAKER: E Everett — ADDRESS: Twin Falls

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28518
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

2. FULL NAME Bonnie Coghill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married

6. DATE OF BIRTH. Dec 8 1 (Month) (Day) (Year)

7. AGE 57 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Conn

10. NAME OF FATHER Henry Smith

11. BIRTHPLACE OF FATHER (State or Country) Conn

12. MAIDEN NAME OF MOTHER Julia Hamilton

13. BIRTHPLACE OF MOTHER (State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Clay Smith
(Address) Twin Falls

15.
Filed Jan 27 1920 John H. Caughlin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920 to Jan 25 1920 that I last saw her alive on Jan 25 1920 and that death occurred on the date stated above, at 8.30 M.

The CAUSE OF DEATH* was as follows:
Intestinal paralysis following gall bladder operation

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... Yrs. 1 mos. 5 ds.

(Signed) H. W. Allan M. D.
Jan 26 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Idaho — **DATE OF BURIAL** 1-27-20

20. UNDERTAKER L. O. Ewert — **ADDRESS** Twin Falls

INK—THIS IS A PERMANENT RECORD.
carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
main terms, so that it may be properly classified. Exact statement
ation is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28522
Registered No. .....

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116

2. FULL NAME King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 9th (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Frank L. King.

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Inma Whitman

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. P. Stratton
(Address) Salmon, Ida

15.
Filed 1/10 1920 M. Deming Green
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1920, to Jan 9 1920, that I last saw him alive on Jan 9th 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Probably delayed
dyhiny as result of
dry birth.
(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) O. P. Stratton M. D.
19..... (Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon, Idaho. DATE OF BURIAL: 1-10 1920

20. UNDERTAKER F. L. King ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2 [illegible]
File No. 28524
Registered No. 1

1. PLACE OF DEATH.
County of Benewah
City of Plummer Ida (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Arthur Williams

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. March (Month) 1 (Day) 1868 (Year)

7. AGE: 51 Yrs. 9 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer around Sawmill
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Haywood County Tennessee

10. NAME OF FATHER: Billy Williams

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Christina Daybury

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Jno A Williams
(Address) Plummer Ida

15. Filed Jan. 13 1920 W. A. Jaeger Local Registrar

BYRD - RICH CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1919, to Jan. 11 1920, that I last saw him alive on Jan 11 1920 and that death occured on the date stated above, at 11 55 A.M.

The CAUSE OF DEATH* was as follows:
Phthisis Pulmonalis

(Duration) 1 Yrs. 8 mos. — ds.
Contributory (Secondary) Asthenia
(Duration — yrs. 2 mos. — ds.

(Signed) J. W. Didier M. D.
1-13 1920 (Address) Plummer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death? ✓
Former or usual residence Missouri

19. PLACE OF BURIAL OR REMOVAL: Plummer, Idaho — DATE OF BURIAL: Jan 13 1920

20. UNDERTAKER: W. A. Jaeger — ADDRESS: Plummer Idaho

Form V. S. No. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28525
Registered No. 62

1. PLACE OF DEATH. Registration District No. 97
County of Lewis
City of Nezperce (No. ....., ... St.)
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lloyd Wilbur Whiting

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: April (Month) 2 (Day) 1854 (Year)

7. AGE: 65 yrs. 7 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ashland Oregon

10. NAME OF FATHER: Wm L. Whiting

11. BIRTHPLACE OF FATHER (State or Country): Kentuckey

12. MAIDEN NAME OF MOTHER: Madaline Wilshire

13. BIRTHPLACE OF MOTHER (State or Country): Calla.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W L Whiting
(Address) Omak Wash

15. Filed 2 — 11 1920 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb — 10 — 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1920 to Feb 10 1920 that I last saw h— alive on Feb 9 1920 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Tobacco Pneumonia

..... (Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James F Gist M. D.
..... 19..... (Address) Nezperce

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce Idaho — DATE OF BURIAL: 2 — 11 1920

20. UNDERTAKER: Albert Huff — ADDRESS: Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 6. 12 M.-7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28526
Registered No. 51

1. PLACE OF DEATH. Registration District No. 47
County of Lewis Primary Registration District No.
City of Nezperce (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. Freddie Maker

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: May (Month) 10 (Day) 1894 (Year)

7. AGE: 25 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Conway Wash

10. NAME OF FATHER: James Maker

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Lizzie Grey.

13. BIRTHPLACE OF MOTHER (State or Country): Memphis Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lizzie Maker
(Address) Nezperce Idaho

15.
Filed 2-11 1920 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-3 1920 to Feb-3 1920
that I last saw h alive on Jan 3 1920
and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) yrs. mos. 2 ds.
Contributory (Secondary) Influenza
(Duration) 0 yrs. mos. 7 ds.

(Signed) John F Gust M. D.
19 (Address) Nezperce Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce Idaho
DATE OF BURIAL: 2-5 1920

20. UNDERTAKER: Albert Huff
ADDRESS: Nezperce Ida

N. B.—Every item of information should be carefully supplied. Exact statements are required. See CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28527
Registered No. .....

Registration District No. 479
Primary Registration District No. 2178
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ida
City of Caldwell

2. FULL NAME Robert McGregor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Dec (Month) 12 (Day) 1879 (Year)
7. AGE: 40 Yrs. 1 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Wis
10. NAME OF FATHER: Alexander McGregor
11. BIRTHPLACE OF FATHER (State or Country): Don't Know
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L B Campbell
(Address) Weiser Ida
15. Filed 1/16 1920 191 .....
J J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 15th (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 14th 1920, to Jan 15th 1920, that I last saw him alive on Jan 15th 1920, and that death occured on the date stated above, at 1.10 P.M.
The CAUSE OF DEATH* was as follows:
Accident
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. E. Brigham M. D.
1/15 1920 (Address) Dr. Brigham Ramsey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Removed to Weiser Ida — DATE OF BURIAL: 1/17 1920
20. UNDERTAKER: J J Johnson — ADDRESS: Ramsey Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SRRS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28528
Registered No. .....

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4 9 2/28
Primary Registration District No. .....

2. FULL NAME Kentuck Corbett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. About (Month) (Day) 1820 (Year)
7. AGE: about 100 years. Yrs. Mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Dsi-tso-lin-kahn
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Nancy ---
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Paul F Leorbett
(Address) Kamiah Ida
15. Filed Jany 12 1920 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 11 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 191 to 191, that I last saw h alive on 191, and that death occured on the date stated above, at 11:30 P.M.
The CAUSE OF DEATH* was as follows: Probably old age
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ind Cem No 1. Kamiah — DATE OF BURIAL: 1/13 1920
20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 49

Primary Registration District No. 2128

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28529

Registered No. .....

1. PLACE OF DEATH.

County of Latah

City of Kamiah

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caleb Powers

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. January (Month) 12 (Day) 1900 (Year)

7. AGE: 19 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Powers

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Agnes

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Powers

(Address) Kamiah Ida

15. Filed June 9 1920

C J Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1 1919, to January 5 1920, that I last saw him alive on January 5 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 1 Yrs. 4 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C T Wyman M D

Jan 19 20 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind. Cem No 1. Kamiah — DATE OF BURIAL: Jan 10 1920

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 49

Primary Registration District No. 3428

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28530

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis

City of Idaho

If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

2. FULL NAME Clarence Moffett

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec 25 (Month) (Day) 1919 (Year)

7. AGE ..... Yrs. 1 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kamiah Ida

10. NAME OF FATHER Harry Moffett

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Sarah Monteith

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Harry Moffett

(Address) Kamiah

15. Filed Jan 6 1920

Local Registrar

BYRNE - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 6 1920

January (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 5 1920, to Jan 6 1920, that I last saw h.. alive on Jan. 5th 1920, and that death occured on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Bryan M. D.

1/4 1920 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kamiah Soldiers Mem. | DATE OF BURIAL: Jan 7 1920

20. UNDERTAKER: C. J. Johnson | ADDRESS: Kamiah Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28531
Registered No. .....

Registration District No. 49
Primary Registration District No. 2128
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Lewis
City of Kamiah

2. FULL NAME Jemima Frank

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 13 (Day) 1919 (Year)

7. AGE: Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Sam Frank

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Priscilla Corbett

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lydia A Corbett
(Address) Kamiah Ida

15. Filed 2/28 1920
J J Johnson
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920, to Feb 2 1920, that I last saw her alive on Feb 1st 1920, and that death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:
Tetanus pneumonia post

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Bryan M. D.
2/28 1920. (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pres. Cem No 1 — DATE OF BURIAL: 2/3 1920

20. UNDERTAKER: J Johnson — ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2129
File No. 28532
Registered No. .....

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Kip Kip Pelican

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 19 (Day) 1907 (Year)

7. AGE: 12 Yrs. 11 Mos. 13 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harrison Kip Kip Pelican

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Daisy Hoyt Kip Kip Pelican

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Daisy Kipkip
(Address) Kamiah Ida.

15. Filed 2/1 1920
J. Johnson
Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1919, to Jan 1920, that I last saw her alive on Jan 31st 1920, and that death occured on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Bryan M. D.
2/3 1920 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kamiah Mem. Kip Kip Ind. Private cem. | DATE OF BURIAL: 2/2 1920

20. UNDERTAKER: J Johnson | ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 49

Primary Registration District No. 2128

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28533

Registered No. .....

1. PLACE OF DEATH.

County of Kevus

City of Kenmah

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephen Axtell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 1 (Day) 871 (Year)

7. AGE: about 49 Yrs. 1 Mos. ? ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: Susan Gillmore

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mathias Ezekiel

(Address) Kamiah Ida

15. Filed 2/2 1920

C. J. Johnson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1919, to about 1920, that I last saw h[illegible] alive on Jan. 20 1920, and that death occured on the date stated above, at 10A M.

The CAUSE OF DEATH* was as follows:

Acute pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Arteriosclerosis

(Duration 2 yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

2/11 1920 (Address) Kamiah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pres. Cem. No 1. DATE OF BURIAL: 2/3 1920

20. UNDERTAKER: C. J. Johnson ADDRESS: Kamiah Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28534

Registered No. .....

1. PLACE OF DEATH

County of Latah

City of Kamiah

Registration District No. 49

Primary Registration District No. 2128

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Priscilla Blackeagle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. About (Month) 1848 (Day) 1 (Year)

7. AGE About 72 years ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Blackeagle

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Blackeagle

(Address) Kamiah Ida

15. Filed 1/23 1920

C. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1917, to Jan. 22 1920, that I last saw h.. alive on Jan. 15th 1920, and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute Enteritis

(Duration) 2 yrs. 1 mos. ..... ds.

(Signed) C. A. Bryan M. D.

1/22 1920 (Address) Kamiah Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kamiah Cem. No 2 — DATE OF BURIAL: 1/24 1920

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28536

Registered No. 1

1. PLACE OF DEATH.

County of Lewis

City of Vollmer Ida (No. .... St.)

Registration District No. 62

Primary Registration District No. 2129

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Curtis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 6 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois Ida.

10. NAME OF FATHER Chester Lincoln Curtis

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Connie Mae Hoppes

13. BIRTHPLACE OF MOTHER (State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chester L Curtis
(Address) Vollmer Idaho

15. Filed 1/6 1920 P E Dunlap Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to Jan 6 1920; that I last saw him alive on Jan 6 1920, and that death occured on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:
Premature child
(7 months)

..... (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

1/6 1920 (Signed) P E Dunlap M. D.
(Address) Vollmer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho cemetery Ida. DATE OF BURIAL: 1/7 1920

20. UNDERTAKER: Stark Fuller & Dunlap Co (R E L) Stark Fuller & Dunlap Co. ADDRESS Vollmer Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 60

Primary Registration District No. 2129

File No. 28537

Registered No. 2

County of Lewis

City of Lew. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Horace Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH. July (Month) 21 (Day) 1887 (Year)

7. AGE 32 Yrs. 6 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Augustus Brown

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Connie Nortwine

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Augustus Brown
(Address) Worley Idaho

15. Filed 1-16 1920 R E Dennison Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:
Suicide due to gunshot
from Pistol ball in water
Instant death
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.

(Signed) John H Best M. D.
1/6 1920 (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Worley Idaho — DATE OF BURIAL 1-17 1920

20. UNDERTAKER W E Sudduth — ADDRESS Worley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of Certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28539
Registered No.

1. PLACE OF DEATH.
County of Camas
City of Manard
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58th
Primary Registration District No. 2138
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ella Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 12th (Day) 1918 (Year)

7. AGE: 1 yrs. 2 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Henry H Cox

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Adelia Moon

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry H. Cox
(Address) Manard, Idaho.

15.
Filed Feb. 9 1920. L Wilencheck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 28th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18 1920, to Jan 28th 1920 that I last saw her alive on Jan 28th 1920, and that death occurred on the date stated above, at 6:30 P M.

The CAUSE OF DEATH* was as follows:
Erysepelas
..... (Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary): Broncho-pneumonia
..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) L Wilencheck M. D.
Feb 9 1920 (Address) Fairfield, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Manard, Idaho
DATE OF BURIAL: Jan. 30 1920

20. UNDERTAKER
ADDRESS

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 28540
Registered No. 68

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruben S. Cox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 15 (Day) 1847 (Year)

7. AGE: 72 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Samuel Cox

11. BIRTHPLACE OF FATHER (State or Country): Not Known Mrs.

12. MAIDEN NAME OF MOTHER: Eliza Hicks

13. BIRTHPLACE OF MOTHER (State or Country): Not Known Mrs.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Sayre
(Address) Troy Idaho

15. Filed Jan 20 1920 N H Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 18th 1920 to ..... 19....., that I last saw him alive on Jan 18th 1920, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Old age
(Duration) 7½ yrs. ..... mos. ..... ds.

(Signed) F. W. Leitch M. D.
1/20 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Randall Flat Cemetery — DATE OF BURIAL: Jan 20 1920

20. UNDERTAKER: Glen Grice — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

PLACE OF DEATH

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28541
Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tracey Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 24 (Day) 1902 (Year)

7. AGE: 17 Yrs. 4 Mos. 15 ds.

IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Peter Johnson

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: Emma Daty

13. BIRTHPLACE OF MOTHER: Wisconsin (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ella C Hustenson
(Address) Moscow Idaho

15. Filed Jan 9 1926. N H Carruthers Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1926 to Jan 8 1926 that I last saw h[illegible] alive on Jan 4 1926 and that death occurred on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows: Intestinal obstruction (ascending colon)

.....(Duration) ..... Yrs..... mos. 8 ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) J. H. Clarke M. D.

Jan 9 1926 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Jan 12 1926

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2852
Registered No. 76
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Blackman Eldred Laurence

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 16 (Day) 1829 (Year)

7. AGE: 90 Yrs. 8 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Carpenter

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Daniel Laurence

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Amy Eldred

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. D. Laurence
(Address) 4703 - 7th Ave NE Seattle Wash

15. Filed Jan 15 1920 N. H. Carithers Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to Jan 14 1920
that I last saw him alive on Jan 14 1920.
and that death occurred on the date stated above, at 9-4 M.
The CAUSE OF DEATH* was as follows:
Endocarditis (chronic)
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) old age
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) J. N. Clarke M. D.
1/15 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Jan 16 1920

20. UNDERTAKER: Allen Grace — ADDRESS: Moscow

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Moscow

If death occurs away from usual residence, give facts, called for under special information.

Registration District No. 101

Primary Registration District No. 10 11

(No. ..... St.)

File No. 28543

Registered No. 74

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Lorenza Duffy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug. 28 1892 (Month) (Day) (Year)

7. AGE: 37 Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington.

10. NAME OF FATHER: Horatio J. Duffy.

11. BIRTHPLACE OF FATHER (State or Country): Missouri.

12. MAIDEN NAME OF MOTHER: Ida B. Long.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas H. Duffy

(Address) Centralia Wash

15. Filed Jan 31 1920 W. H. Luthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 28 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1920, to Jan 28 1920, that I last saw h[illegible] alive on Jan 28 1920 and that death occurred on the date stated above, at 1:10 A.M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Cudsi M. D.

1/31 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Centralia Wash. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Allen Spice ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-17 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28544
Registered No. 69

Registration District No. 61
Primary Registration District No. 1011

1. PLACE OF DEATH
County of Idaho
City of ...
If death occurs away from usual residence, give facts called for under special information.
(No. ..., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Berthold Augusta Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 30 (Day) 1901 (Year)

7. AGE: 18 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: George A. Smith

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: Jennie E. Hughes

13. BIRTHPLACE OF MOTHER (State or Country): Wash. D.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): G. F. Smith
(Address): Weiser Idaho

15. Filed Jan 10 1920 N. H. Carothers Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1920 to Jan 9 1920
that I last saw h~~e~~ alive on Jan 9 1920
and that death occurred on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:
Inspetave gastritis
...
...
...(Duration) ... Yrs. ... mos. 36 hours
Contributory (Secondary) Bad complication of
...(Duration) ... Yrs. ... mos. ... ds.
(Signed) F. W. Leitch M. D.
1/10 1920 (Address) Grasmere Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL ... 191...

20. UNDERTAKER: Allen Price — ADDRESS: Moscow Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28545

Registered No. 70

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Regena B Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH: Aug (Month) 6 (Day) 1866 (Year)

7. AGE: 53 Yrs. 5 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Ole Gold Larsen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Not Known here

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margret Johnson
(Address) Spokane Wash

15. Filed Jan 28 1920 N H Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from dec'd not about — 19..., to ..... 19...,
that I last saw h[illegible] alive on Jan 26 1920,
and that death occurred on the date stated above, at 10 45 A. M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. N. Clarke M. D.
1/28 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Jan 29 1920

20. UNDERTAKER: Lem Price — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 28546
Registered No. 71

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy B Heath

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April (Month) 11 (Day) 1861 (Year)

7. AGE: 58 Yrs. 8 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Jeremiah Bailey

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) N. E. Heath

15. Filed Feb 1 19 2d Kendrick Ida
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 1920 to Jan 31 1920 that I last saw h[illegible] alive on Jan 31 1920 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. H. Carithers M. D.
1/31 1920 (Address) Moscow.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL: Southwick Ida
DATE OF BURIAL: Feb 2 1920

20. UNDERTAKER: Glen Grice
ADDRESS: Moscow Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28547

Registered No. 72

1. PLACE OF DEATH

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Jane Clarke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH: Jan (Month) 9 (Day) 1834 (Year)

7. AGE: 86 Yrs. ..... Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: William Dobbs

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Not Known Here

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Theadora Clarke

(Address) Moscow

15. Filed Jan 19 1920 W.H. Carruthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1919, to Jan 11 1920, that I last saw h.. alive on Jan 11 1920, and that death occurred on the date stated above, at 1130 a. M.

The CAUSE OF DEATH* was as follows: Mentally superiority of old age with gradually weakening of the heart

(Duration) 86 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Leitch M. D.

1/19 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	1/19 1920

20. UNDERTAKER: Elmer Gross ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28548

Registered No. 73

1. PLACE OF DEATH

County of Latah

City of Moscow (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Allen Burn.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1892 (Year)

7. AGE: 27 Yrs. 3 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer
(b) General nature of industry, business or establishment in which employed (or 'employer'): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Homer Burn.

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Anna Frazier

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Anna Watling
(Address) Moscow Ida

15. Filed Jan 23 1920 N. H Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920, to Jan 23 1920, that I last saw him alive on Jan 23 1920, and that death occurred on the date stated above, at 330 A.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.

1/23 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 1/24 1920

20. UNDERTAKER: Reed Price & Co | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 62
Primary Registration District No. 242

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28549
Registered No. 1

1. PLACE OF DEATH.
County of Latah
City of Genesee
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Milton Rist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 28 (Day) 1867 (Year)

7. AGE: 52 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): In Elevator and warehouse

9. BIRTHPLACE (State or Country): Bowen Illinois

10. NAME OF FATHER: Joseph Rist

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Nancy E. Lee

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Harry Wood (Daughter)
(Address) Genesee, Idaho.

15. Filed 1-30 1920 W. T. Eheman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h— alive on — 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute
Fracture of skull

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Eheman M. D.
1-30 1920 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee Idaho — DATE OF BURIAL: 2-4 1920

20. UNDERTAKER: F. E. Lauer — ADDRESS: Genesee

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Troy

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64

Primary Registration District No. 9147

(No. ..., ... St.)

File No. 28550

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Sletto

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: November 19th 1884 (Month) (Day) (Year)

7. AGE: 35 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Barber

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: Martin Gottenborg

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Amelia Gunderson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. C. Harris

(Address) Troy Idaho

15. Filed Feb 2 1920 — J E Pickard, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 31 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920, to Jan 31 1920, that I last saw h.... alive on Jan 31 1920, and that death occurred on the date stated above, at 5-40 A M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. McColl M. D.

Jan 31 1920 (Address) Troy Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Feb 3 1920

20. UNDERTAKER: J E Pickard — ADDRESS: Troy Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 64
Primary Registration District No. 2144
(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28551
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Latah
City of Troy

2. FULL NAME Paul Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 22 1839 (Month) (Day) (Year)

7. AGE: 81 Yrs. 9 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Smith
(Address) Troy Idaho

15. Filed Jan 20 1920 J E Pickerel Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 18 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1919, to January 17 1920, that I last saw him alive on January 17 1920 and that death occurred on the date stated above, at 12 15 A M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Mc Call M. D.

Jan 20 1920. (Address) Troy Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burial Ridge — DATE OF BURIAL: 21 1920

20. UNDERTAKER: J E Pickerel — ADDRESS: Troy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
(No. ..... St.)

File No. 28552
Registered No. .....

1. PLACE OF DEATH.
County of Latah.
City of Potlatch.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Inf. Phillips.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant.
6. DATE OF BIRTH. Jan. (Month) 8 (Day) 1920 (Year)
7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many 3 hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER A. J. Phillips.
11. BIRTHPLACE OF FATHER (State or Country) Tenn
12. MAIDEN NAME OF MOTHER Sarah. Metcalf.
13. BIRTHPLACE OF MOTHER (State or Country) Ky.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. J. Phillips.
(Address) Potlatch.
15. Filed Jan 8 – 1920. W. W. Thompson Local Registrar

SYMS - YORK CO., PTRS. & BOXES. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 8 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec Jan 8 1920, to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Inanition – six months gestation
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E. K. Wolf. M. D.
1/10 1920 (Address) Bovine Trust.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Evergreen Cemetery — DATE OF BURIAL 1/9/1920
20. UNDERTAKER Parents — ADDRESS Potlatch

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28553
Registered No.

1. PLACE OF DEATH.
County of Latah
City of (No., St.)

Registration District No. 66
Primary Registration District No. 2145

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tom Keeney

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH: January (Month) 23rd (Day) 1919 (Year)

7. AGE: 1 yrs. 6 mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Latah Co Ida

10. NAME OF FATHER: Wayne Keeney

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Mirtrid Porter

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wayne Keeney
(Address) Potlatch Ida

15.
Filed Jan. 27th 1920 Dr. J. W. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 25 (Day) 19XX (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 19XX, to Jan 24 19XX that I last saw him alive on Jan 24 19XX and that death occurred on the date stated above, at 3 9 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ~ yrs. ~ mos. 17 ds.

Contributory (Secondary) none (Duration) yrs. mos. ds.

(Signed) Ernest V. Dean M. D.
Jan 25 1920 (Address) Potlatch Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: Jan 25 19XX

20. UNDERTAKER: Parents — ADDRESS: Potlatch

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145.
File No. 28554
Registered No. .....

1. PLACE OF DEATH.
County of Latah
~~City~~ of Potlatch
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ireo Genette Jenkins

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH.
Jan (Month) 3 (Day) 1920 (Year)

7. AGE
.....Yrs. ~~.....~~ Mos. ~~.....~~ ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Potlatch Ida

10. NAME OF FATHER: Fred Jenkins

11. BIRTHPLACE OF FATHER
(State or Country) Wash.

12. MAIDEN NAME OF MOTHER: Alta Seely

13. BIRTHPLACE OF MOTHER
(State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred Jenkins
(Address) Potlatch Ida

15.
Filed Jan. 5th 1920
D. J. Thompson
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature birth lues three 7 months
not viable

.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration .....yrs.....mos.....ds.

(Signed) Ernest S. Hume M. D.
1/3 1920 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Ida
DATE OF BURIAL: Jan 4 1920

20. UNDERTAKER: none
ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28569
Registered No. 3

1. PLACE OF DEATH.
Registration District No. 82
Primary Registration District No. 2082 12159
County of Caribou
City of Soda Springs (No. Tackley Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ray Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct 9th 1898
(Month) (Day) (Year)

7. AGE: 21 yrs. 2 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranch Hand
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: William Roberts

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Vena Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Tilley
(Address) Lava Hot Springs Idaho

15.
Filed Jan 5 1920 E. Ellis Kinney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 5th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1920, to Jan 5 1920, that I last saw him alive on Jan 5 1920, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Ascending gunshot wound of Right thigh
Infection developed

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Ellis Kinney

(Duration) ..... yrs. ..... mos. 5 ds.
(Signed) Ellis Kinney M. D.
Jan 5 1920 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Lava Hot Springs | DATE OF BURIAL: Jan 7 1920

20. UNDERTAKER: Shumacher & Hays | ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 82
Primary Registration District No. 2159
File No. 28570
Registered No. 1

1. PLACE OF DEATH
County of Bannock
City of Pocatello Ida
(No. Cara Mat Camp St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Nooper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Wid

6. DATE OF BIRTH: July (Month) 4 (Day) 1885 (Year)

7. AGE: 35 Yrs. 6 Mos. 16 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: J. L. Hooper

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Doley Wells

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Hooper
(Address) Burley Idaho

15.
Filed ..... 19 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920, to Jan 22 1920, that I last saw h.im alive on Jan 22 1920, and that death occurred on the date stated above, at 3.50 P.M.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) not known Yrs. mos. ds.
Contributory (Secondary) Nephritis
(Duration) not known yrs. mos. ds.

(Signed) O. D. Henning M. D.
1/22 1920 (Address) Cara Mat Camp Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida
DATE OF BURIAL: 1/23 1920

20. UNDERTAKER: W. H. Walker
ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 82
Primary Registration District No. 2459
File No. 28571
Registered No. 2

1. PLACE OF DEATH.
County of Caribou
City Soda Springs (No.) Dr. Hackley Hospital
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lavinia N. Kesler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec 24th (Month) (Day) 1862 (Year)

7. AGE: 67 yrs. — mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John H. Bankhead

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Nancy Crosby

13. BIRTHPLACE OF MOTHER (State or Country): Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Kesler
(Address) Alexandria Idaho

15. Filed Jan 9 1920 Earl Kinsey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 9th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1920 to Jan 9 1920 that I last saw her alive on Jan 9 1920 and that death occurred on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia Wave

(Duration) 1 yrs. mos. ds.
Contributory (Secondary) None
(Duration) yrs. mos. ds.

(Signed) Earl Kinsey M. D.
Jan 9 1920 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wellsville Utah | DATE OF BURIAL: Jan 11 1920

20. UNDERTAKER: Schumacher & Hall | ADDRESS: Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Central
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83
Primary Registration District No. 2160

File No. 28572
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thelma Quallman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 2 (Day) 1919 (Year)

7. AGE: ... yrs. ... mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Central - Idaho.

10. NAME OF FATHER: John Quallman

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Della May Decker

13. BIRTHPLACE OF MOTHER (State or Country): Texas - U. S. a.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1919, to Jan 2 1920
that I last saw her alive on Dec 30 - 1919
and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:
Cardiac impairment,
hereditary - [Blue baby]

(Duration) ... yrs. ... mos. 13 ds.

Contributory .....
(Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) John A. Hubbard M. D.
Jan 3 1920 (Address) Grace, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Central - Idaho. DATE OF BURIAL: Jan 5 - 1919

20. UNDERTAKER ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 85
Primary Registration District No. 2185
(No. ..... St.)

File No. 3574 1
Registered No. 8

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonner
City of Priest River, da.

2. FULL NAME James Bullock.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH

Jan (Month) 2 (Day) 1847 (Year)

7. AGE

73 Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE

(State or Country) Wis.

10. NAME OF FATHER

Wm Bullock

11. BIRTHPLACE OF FATHER

(State or Country) England.

12. MAIDEN NAME OF MOTHER

Not known

13. BIRTHPLACE OF MOTHER

(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B Bullock
(Address) Spokane Wash.

15.

Filed Feb 1 1920 C P Gutzlaff
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1920, to Jan 15 1920, that I last saw him alive on Jan 15 1920, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia,

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C P Gutzlaff M. D.
(Address) Priest River,

Jan 16 1920

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Priest River — **DATE OF BURIAL** Jan 18 1920

20. UNDERTAKER Wm Degner, C P G — **ADDRESS** Newport Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28575

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 85
Primary Registration District No. 2185
File No. 1
Registered No. 9

1. PLACE OF DEATH
County of Bonner
City of Priest River, Ida.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. W. Sutton.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH
Nov (Month) 4 (Day) 1843 (Year)

7. AGE
76 Yrs. 2 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinist.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) N.Y.

10. NAME OF FATHER
Lyman C. Sutton

11. BIRTHPLACE OF FATHER (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER
Janewette Eighmy

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Sutton
(Address) Priest River, Ida.

15.
Filed Feb 1 1920
C. P. Gehlhoff
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1919, to March 15 1919, that I last saw him alive on March 15 1919, and that death occurred on the date stated above, at 6.45A M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Gehlhoff M. D.
Jan 19 1920 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Priest River Ida	Jan 20 1920
20. UNDERTAKER Neighbor	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1 28516
Registered No. 6

1. PLACE OF DEATH

Registration District No. 85
Primary Registration District No. 2185

County of Bonner
City of Priest River, Idaho.
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie Gugler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August 22 (Month) (Day) 1920 (Year)

7. AGE: 7 Yrs. 4 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harry Gugler

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Elva Walker

13. BIRTHPLACE OF MOTHER (State or Country): South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. P. Gezler

(Address) PRIEST RIVER, IDAHO

15. Filed Feb 1 1920 C. P. Gezler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 3, 1920. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1 1920, to January 3 1920, that I last saw h[illegible] alive on January 2 1920, and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows: ~~Diphtheria~~ Diphtheria

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Gezler M. D.

Jan. 3 20 (Address) Priest River, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River Idaho. DATE OF BURIAL: Jan. 5 19 20

20. UNDERTAKER: Wm. Davis ADDRESS: Newport, Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

2 #9

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

35 28577

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner

Registration District No.

Primary Registration District No. 2185

File No. 1

City of Priest River Idaho.

(No. , St.)

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Serafrino Bossio

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 19 20 (Month) (Day) (Year)

7. AGE: 73 Yrs. 7 Mos. 20 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE: Italy (State or Country)

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER: Italy (State or Country)

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER: Italy (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tony F.

(Address) PRIEST

15. Filed Feb 1 1920 C P Gutzloff Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 9 20 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 9 1920 to January 9 1920, that I last saw her alive on January 9 1920, and that death occurred on the date stated above, at One P.M.

The CAUSE OF DEATH* was as follows:

~~Old Age~~ Apoplexy

(Duration) — Yrs. — mos. 1 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) C. P. Gutzloff M. D.

Jan. 9 1920 (Address) PRIEST RIVER, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River Idaho.

DATE OF BURIAL: Jan. 12 1920

20. UNDERTAKER: Wm. Davis

ADDRESS: Newport, WASH.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

28579

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Lewis
City of Nezperce

Registration District No. 44
Primary Registration District No.
(No. , St.)

File No. 50
Registered No. 2122

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Jane Hoover

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widowed

6. DATE OF BIRTH: Jan 27 1853 (Month) (Day) (Year)

7. AGE: 66 yrs. 5 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers wife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wayne Co. Ohio

10. NAME OF FATHER: Jake Steel

11. BIRTHPLACE OF FATHER (State or Country): Lancaster Co Penn

12. MAIDEN NAME OF MOTHER: Sarah Ann Weaver

13. BIRTHPLACE OF MOTHER (State or Country): Lancaster Co Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Anna E. Smith
(Address): Nezperce Idaho

15.
Filed 2-7 1920 Albert Huff
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan - 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan - 17 1920, to Jan - 27 1920
that I last saw h alive on Jan. 24 1920
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Aortic Insufficiency.

(Duration) 15 yrs. mos. ds.
Contributory (Secondary) Arteriosclerosis
(Duration) 15 yrs. mos. ds.

(Signed) John H. Gist M. D.
1920 (Address) Nezperce Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce Idaho
DATE OF BURIAL: 2-3 1920

20. UNDERTAKER: Albert Huff
ADDRESS: Nezperce Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Jan 29 - 20

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

28581

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 47
County of Lewis Primary Registration District No.
City of Nezperce (No. , St.)
File No. 419
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME F. L. Shaw

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: 54 (Years) Nov (Month) 3 (Day) 1865 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mechanic
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Luther Shaw

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mary Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Shaw
(Address) Livingston Mont.

15.
Filed 2 2 1920 Albert Huff
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1920 to Jan 29 1920
that I last saw h alive on Jan 29 1920
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Influenza ?
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
..... 19..... (Address) Nezperce Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Columbus Mont. Removal
DATE OF BURIAL ..... 191...

20. UNDERTAKER: W. A. Shaw
ADDRESS: Orofino Idaho

...RESERVED FOR BINDING
...UNFADING INK—THIS IS A PERMANENT RECORD.
...be carefully supplied. AGE should be stated EXACTLY. PHYSI-
...in plain terms, so that it may be properly classified. Exact state-
...See instructions on back of certificate.
...of OCCUPATION is very important.

...BOOK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58
Primary Registration District No. 2164
File No. 28582
Registered No.

1. PLACE OF DEATH

County of Washington
City of Heath (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Raymond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word.)

6. DATE OF BIRTH August 13 (Month) (Day) 1875 (Year)

7. AGE 45 Yrs. 5 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Mathew C Mackey

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Maginnis

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Raymond Sr

(Address) Heath Ida

15. Filed Feb 12 1920 C E Schmuck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1920, to Jan 28 1920, that I last saw h[illegible] alive on Jan 28 1920, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobular Bilateral

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. 1 mos. 7 ds.

(Signed) S Hopkins M. D.

Jan 7 1919. (Address) Cambridge Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Heath

DATE OF BURIAL Jan 22 1920

20. UNDERTAKER Jas Anderson

ADDRESS Cambridge

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 88
Primary Registration District No. 2164
File No. 28583
Registered No.

1. PLACE OF DEATH
County of Washington
City of Cambridge
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Cumberland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan ~~31~~ (Month) Jan (Day) 31 1920 (Year)

7. AGE: 8 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Washington Co Ida

10. NAME OF FATHER: Roy Cumberland

11. BIRTHPLACE OF FATHER (State or Country): Missouria

12. MAIDEN NAME OF MOTHER: Caric Stahn

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. T. Cumberland
(Address) Cambridge Idaho

15. Filed Feb 12 1920 O. E. Schmutz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/6/20 19..., to 2/8/20 19..., that I last saw him alive on 2/8/20 19..., and that death occurred on the date stated above, at 5:00 P. M.

The CAUSE OF DEATH* was as follows:
Acute Indigestion

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Cardiac Insufficiency
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. E. Schmutz M. D.
19..... (Address) Cambridge Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho
DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER: Jos Kuehlman
ADDRESS: Cambridge Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28585

1. PLACE OF DEATH
County of Washington
City of Cambridge
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2164
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Evgie V. Hutchinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	W	married

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1887 (Year)

7. AGE: 31 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Work
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pennsylvania Iowa

10. NAME OF FATHER: G W Steward

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Virginia Wheelhouse

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Evgie V. Hutchinson
(Address) Indian Valley Idaho

15. Filed Feb 6 1920 O E Schmutz Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Sept 4 1920, that I last saw he alive on Sept 4 1920, and that death occurred on the date stated above, at 12 5/6 M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration) .....yrs.....mos. 4 ds.

(Signed) O E Schmutz M. D.
Feb 7 1920 (Address) Cambridge Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Indian Valley Ida	Feb 6 1920

20. UNDERTAKER	ADDRESS
Jno Henderson	Cambridge Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58
Primary Registration District No. 2164
File No. 30993
Registered No.

1. PLACE OF DEATH
County of Washington
City of Cambridge
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Asgir V Hustetuson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1889 (Year)

7. AGE: 31 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Des Moines Iowa

10. NAME OF FATHER: G W. Stuart

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed Aug 21 20 [illegible] Local Registrar

COPY

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920, to Feb 4 1920, that I last saw her alive on Feb 4 1920, and that death occurred on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia
(b)
(c)
(d)
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C E Schmutz M. D.
Feb 4 1920 (Address) Cambridge Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meadows Valley
DATE OF BURIAL: Feb 6 1920

20. UNDERTAKER: Jas Hedelson
ADDRESS: Cambridge Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 28593
Registered No.

1. PLACE OF DEATH

County of Nezperce
City of Culdesac
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lula Wilcox Rogers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: January (Month) 20 (Day) 1877 (Year)

7. AGE: 43 Yrs. 5 Mos. 4 ds. (42 11 26)

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House-wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Andrew J. Wilcox

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Mary Bunnell

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Wilcox
(Address) Culdesac, Idaho

15. Filed Jan 25 1920 E. E. Watts, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 19 1920 to Jan. 24 1920 that I last saw h.. alive on Jan. 24 1920, and that death occurred on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:

"Secondary Pneumonia"

(Duration) 0 Yrs. 0 mos. 2 ds.
Contributory (Secondary) Influenza
(Duration) 0 yrs. 0 mos. 18 ds.

(Signed) W. A. Wood Gore M. D.
1/24 1920 (Address) Pierce, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: M. F. C. Melrose | DATE OF BURIAL: Jany 25 1920
20. UNDERTAKER: C. E. Goodland | ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
File No. 28394
Registered No. 35

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. Tammany St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louise Theissen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 17 1 (Month) (Day) (Year)

7. AGE: 19 Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Gus Theissen

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Watson

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George L. Theissen
(Address) Lewiston, Ida

15. Filed Feb 3 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 26 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-24 1920, to 1-26 1920, that I last saw her alive on 1-25 1920, and that death occurred on the date stated above, at 6.15a M.

The CAUSE OF DEATH* was as follows:
Influenza & Pneumonia

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W F McMahan M. D.
1-27 1920 (Address) Lewiston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 1/28 1920

20. UNDERTAKER: Hasson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28595

Registered No. 356

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. ~~816 3rd~~ 819-7th St.)

2. FULL NAME Fred Oral Bolt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 4 (Month) (Day) 1899 (Year)

7. AGE: 20 Yrs. 10 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ethan Allen Bolt

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Nannie E Gilbreth

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Carter

(Address) 819-7th St Lewis

15. Filed Feb 3 1920

Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to Jan 27th 1920, that I last saw h.. alive on Jan 27th 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O C Epperson M. D.

19..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston

DATE OF BURIAL: Jan 30 1920

20. UNDERTAKER: C J Vassar

ADDRESS: Lewiston

Vassar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28396

Registered No. 345

1. PLACE OF DEATH.

Registration District No. 96

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Emma Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November (Month) 17th (Day) 1848 (Year)

7. AGE: 71 Yrs. 2 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Howard

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Francis Duncan

13. BIRTHPLACE OF MOTHER (State or Country): Virginis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Dayton Harris

(Address) Lewiston, Ida.

15. Filed Feb 3 1920 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920, to Jan 25 1920, that I last saw h[illegible] alive on Jan 25 1920, and that death occured on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho.)

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L. Whitlock M. D.

Jan 28 1920 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash — DATE OF BURIAL: Jan 27 1920

20. UNDERTAKER: H R Merchant — ADDRESS: Clarkston Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 2859

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. White Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Darrow.
Registered No. 346
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE:
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: February (Month) 5 (Day) 1877 (Year)

7. AGE: 43 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher of Voice
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New London Connecticut

10. NAME OF FATHER: John R. Darrow

11. BIRTHPLACE OF FATHER (State or Country): U.S.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): U.S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lela M. Garner
(Address) Clarkston

15. Filed Feb 3 1920
Wm E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to Jan 26 1920, that I last saw her alive on Jan 26 1920 and that death occurred on the date stated above, at 1135 P.M.

The CAUSE OF DEATH* was as follows: Pneumonia
Following Influenza

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jean McClure M.D.
1/28 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 7 days. In the State yrs. mos. 7 days
Where was disease contracted if not at place of death? ✓
Former or usual residence Clarkston Wn

19. PLACE OF BURIAL OR REMOVAL: Lewiston | DATE OF BURIAL: 1/30 1920

20. UNDERTAKER: Lewiston | ADDRESS: Lewiston

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28598
Registered No. 347

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital, St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe Kavanaugh,

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Single

6. DATE OF BIRTH: March (Month) 16 (Day) 1886 (Year)

7. AGE: 33 Yrs. 10 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Meatcutter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Gerald Kavanaugh

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizabeth Hunt

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. P. Kavanaugh
(Address) Lewiston Ida

15. Filed Feb 3 1920 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24th 1920, to Jan 27th 1920, that I last saw h.im alive on Jan 27th 1920, and that death occurred on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:

Influenza Pneumonia
(Duration) ..... Yrs. ..... mos. 3 hrs. ..... ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. L. Carson M. D.
19..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Portland Ore	19.....

20. UNDERTAKER J. Lester | ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Carson

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28599
Registered No. 348

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston
(No. 120, 9th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Francis Stanford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married

6. DATE OF BIRTH Oct (Month) 5 (Day) 1900 (Year)

7. AGE 19 Yrs. 3 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Mich

10. NAME OF FATHER Charlie Gamonneg

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Vernie Woodworth

13. BIRTHPLACE OF MOTHER (State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs F A Stanford

(Address) Lewiston Idaho

15. Filed Feb 3 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1920, to Jan 27 1920 that I last saw h.er alive on Jan 27 1920 and that death occurred on the date stated above, at 2.15 A.M.

The CAUSE OF DEATH* was as follows:

Flu - Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) E. L. White M. D.

Jan 28 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston

DATE OF BURIAL 1/30 1920

20. UNDERTAKER E Mason

ADDRESS Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 20000
Registerdd No. 349

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. White Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emiline Barker Phillips
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: May (Month) 27 (Day) 1839 (Year)

7. AGE: 80 Yrs. 8 Mos. 6 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Teacher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: ~~John D. Atkins~~ E. Exter

11. BIRTHPLACE OF FATHER (State or Country): Exeter Mass

12. MAIDEN NAME OF MOTHER: Catherine Barker

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S Atkins
(Address) 217 Second Ave Lewiston

15. Filed Feb 3rd 1920 — Susan E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920, to Jan 28 1920, that I last saw her alive on Jan 28 1920, and that death occurred on the date stated above, at 1220 PM.

The CAUSE OF DEATH* was as follows:

Pneumonia. Broncho.

(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) Hem? Arteriosclerosis
(Duration) yrs. 2 mos. ds.

(Signed) E L White M. D.
Jan 28 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 1/30 1920

20. UNDERTAKER: Gasser — ADDRESS: Lewiston

FORM V. S. No. 5-05 M. 2-29.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28601

Registered No. 336

1. PLACE OF DEATH

Registration District No. 90

Primary Registration District No. 1009

County of Nez Perce

City of Lewiston (No. 925 8th ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherine Roos

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	White	Married

6. DATE OF BIRTH: April 14th (Month) (Day) 185 (Year)

7. AGE: 69 Yrs. 8 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Conrad Young

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis N Roos
(Address) Boise Idaho

15. Filed Jan 3 1926 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7th 1920 to Jan 7th 1920 that I last saw h.. alive on Jan 7 1920, and that death occurred on the date stated above, at 5-0 P.M.

The CAUSE OF DEATH* was as follows:
Arteria sclerosis
General senility

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E-L-White M. D.

Jan 9 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Jan 10 1920

20. UNDERTAKER: Hesser — ADDRESS: Lewiston

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
LEAVE SPACE RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28602
Registered No. 337

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 1448, 7th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Leach

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: November (Month) 8 (Day) 1881 (Year)

7. AGE: 38 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Saline Co. Missouri

10. NAME OF FATHER: L D Porter

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Mary J. Gauldin

13. BIRTHPLACE OF MOTHER (State or Country): Saline Co Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillian E Brock
(Address) Charleston Wash.

15.
Filed Feb 3 1920 Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1919, to Jan 10 1920, that I last saw her alive on Dec 1919, and that death occurred on the date stated above, at 5:10 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Duration) 7 Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) 7 yrs. ... mos. ... ds.

(Signed) O E Pearson M. D.
19... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	1/11 1920
20. UNDERTAKER	ADDRESS
Carson	Lewiston Ida.

Carson.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28603

Registered No. 338

1. PLACE OF DEATH.

County of Nezperce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Dick McElvain

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. February 25 1845
(Month) (Day) (Year)

7. AGE: 74 Yrs. 10 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Samuel McElvain

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Nancy Snyder

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. McElvain
(Address) Asotin

15. Filed Feb 3 1920 Swan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 11 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1919, to Jan 11 1920, that I last saw him alive on Jan 10 1920, and that death occured on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows: Chronic prostatitis with infected urinary bladder.

(Duration) year. Yrs. mos. ds.

Contributory (Secondary)

(Duration Yrs. mos. ds.

(Signed) Paul W. Johnson M. D.

Jan 13 1920 (Address) Clarkston Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. 7 days

Where was disease contracted if not at place of death? ~~not~~

Former or usual residence Clarkston Wash

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash — DATE OF BURIAL: Jan 14 1920

20. UNDERTAKER: H. R. Merchant — ADDRESS: Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 96

County of Nez Perce Primary Registration District No. 1009

City of Lewiston (No. ....., ... St.)

File No. 28604

Registered No. 339

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Mae Brett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	married

6. DATE OF BIRTH Mar ~~February~~ ~~6~~ (Month) (Day) 1873 (Year)

7. AGE 46 yrs. 10 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) West Union Iowa

10. NAME OF FATHER William Johnston

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Emma Burchfield

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jennie Wood
(Address) .....

15.
Filed Feb 3 1920 Roan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
January 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1913, to Jan 13 1920 that I last saw her alive on Jan 13 1920 and that death occurred on the date stated above, at 1035 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
[redacted]
..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Cardio nephritis (Chronic)
..... (Duration) 4 yrs. 6 mos. ..... ds.
(Signed) Elmer G. Brecook M. D.
Jan 15 1920 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: Jan 25 1920

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS. BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1909
File No. 28605
Registered No. 340

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Sarah Chamberlin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 13 (Day) 1850 (Year)

7. AGE: 69 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: John Richardson

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.P. Chamberlain
(Address) Lewiston Ida.

15. Filed Feb 3 1920 Susan E. Bruns
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1920, to Jan 17 1920
that I last saw her alive on Jan 17 1920
and that death occurred on the date stated above, at 1.30 P.M.
The CAUSE OF DEATH* was as follows:

Cancer of bowel

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul W. Johnson M. D.
Jan 29 1920 (Address) Lewiston Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	1/18 1920
20. UNDERTAKER	ADDRESS
E. Dasson	Lewiston I.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28606
Registered No. 341

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 910 Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Wolbeck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brickmason
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): —

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Feb 3rd 1920 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1919 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19— to — 19—, that I last saw h..... alive on — 19—, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: He died quietly While he slept - A natural death - May have had heart Trouble (Duration) or Cerebral hemorrhage Yrs. ..... mos. ..... ds.
Contributory (Secondary) No Cause In Post-Mortem
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Susan E. Bruce M. D.
19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	Jan 20 1920
20. UNDERTAKER	**ADDRESS**
C J Vassar	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28607
Registered No. 342

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston
(No. White Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E. A. Ewall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) married

6. DATE OF BIRTH Sept (Month) 6 (Day) 1874 (Year)

7. AGE 45 Yrs. 4 Mos. 13 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) Maine

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. Ewall

(Address)

15. Filed Feb 3 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14 1920, to Jan 19 1920 that I last saw him alive on Jan 19 1920 and that death occurred on the date stated above, at 9 56 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate. Post Mortem Uraemia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary) Carcinoma of Prostate. Hypertrophy

(Duration) 12 yrs. — mos. — ds.

(Signed) Edgar A Watt M. D.

Jan 21 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston — **DATE OF BURIAL** Jan 21 1920

20. UNDERTAKER J Vassar — **ADDRESS** Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28608

Registered No. 343

Registration District No. 95

Primary Registration District No. 1009

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. Orchards St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H. E. Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: January (Month) 3 (Day) 1856 (Year)

7. AGE: 64 Yrs. Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Orcharding

(b) General nature of industry, business or establishment in which employed (or employer): Fruit grower

9. BIRTHPLACE (State or Country): Lewis Oregon

10. NAME OF FATHER: Henry P Jackson

11. BIRTHPLACE OF FATHER (State or Country): Marietta Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Duncan

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry E Jackson Son

(Address) Lewiston Idaho

15. Filed Feb 3 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 20th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 15 1920, to January 20th 1920 that I last saw h[illegible] alive on Jan 20th 1920 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Hypertension from Interstitial Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O McCasson M. D.

19..... (Address) Lewiston Ida

*State the *Disease Causing Death*; or in deaths *from Violent Causes*, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	1/22 1920
20. UNDERTAKER O Casson	ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28609
Registered No. 344

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances O'Hara
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Not Known (Write the word.)

6. DATE OF BIRTH: ..... 1..... (Month) (Day) (Year)

7. AGE: 50 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Evan E Bruce
(Address) Lewiston

15. Filed Feb 3 1920 Evan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 24 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

..... 1.....
Overdose of Bromide
.....
.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....
.....(Duration) .....yrs.....mos.....ds.

(Signed) Evan E Bruce M. D.
Jan 26 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida	Jan 1920
20. UNDERTAKER: C J Vassar	ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28610

Registered No. 350

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston Ida.

(No. St. Joseph's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME L. P. Burns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED married (Write the word.)

6. DATE OF BIRTH Feb (Month) 26 (Day) 1846 (Year)

7. AGE 70 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: R.R. Contractor

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Andrew Burns

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Miss Mary E Burns

(Address) 1319 - 6th St Lewiston

15. Filed Feb 3rd 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 28 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1918, to Jan 28 1920 that I last saw him alive on Jan 28 1920 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) years Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Daniel W Johnson M. D.

1/29 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Spokane

DATE OF BURIAL ..... 19.....

20. UNDERTAKER C J. Vassar

ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28011

Registered No. 357

Registration District No. 96

Primary Registration District No. 1009

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. White's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Hammond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Feb (Month) 28 (Day) 1900 (Year)

7. AGE: 19 Yrs. 11 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ore

10. NAME OF FATHER: Jim Gordon

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Eliza "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J B Hammond

(Address) Bartlett Oregon

15. Filed Feb 3 1920 Susan E Burns Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Jan 30 1920, that I last saw her alive on Jan 30 1920, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) Pregnancy - 3 months + Complications

(Duration) ..... yrs. 3 mos. ~~6~~ ds.

(Signed) Edgar P. White M. D.

Jan 30 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bartlett Ore

DATE OF BURIAL: Jan 1920

20. UNDERTAKER: C. J. Vassar

ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28612
Registered No. 361

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 116, 9th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia Downie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1875 (Year)

7. AGE: 44 Yrs. 2 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Thomas Bond

11. BIRTHPLACE OF FATHER (State or Country): Nat Iowa

12. MAIDEN NAME OF MOTHER: Varcit

13. BIRTHPLACE OF MOTHER (State or Country): Nat Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E O Downie
(Address) Lewiston

15. Filed Feb 3 1920 Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1920, to ..... 19....., that I last saw h.. alive on Jan 29 1920 and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:

Blood Poisoning

(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 9 ds.
(Signed) L F Inman M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chelan Wn — DATE OF BURIAL 19.....

20. UNDERTAKER: J Vansa — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28613
Registered No. 362

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 1716 East St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Sadie Spengler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	W	Married (Write the word.)

6. DATE OF BIRTH
Dec (Month) 27 (Day) 1890 (Year)

7. AGE
Yrs. 29 Mos. 1 ds. 9
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Alexander Stevens

11. BIRTHPLACE OF FATHER
(State or Country) Scotland

12. MAIDEN NAME OF MOTHER Sarah E Trimmer

13. BIRTHPLACE OF MOTHER
(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A L Stevens
(Address)

15.
Filed Feb 3 1920 Simon E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920 to Jan 31 1920
that I last saw h.e.r alive on Jan 31 1920
and that death occurred on the date stated above, at 8 30 P.M.
The CAUSE OF DEATH* was as follows:
Influenza Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Mitral Regurgitation
(Duration) 4 yrs. ..... mos. ..... ds.
(Signed) E G Braddock M. D.
Feb 1 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	Feb 2 1920

20. UNDERTAKER	ADDRESS
C J Vassar	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28614

Registered No. 363

Registration District No. 96

Primary Registration District No. 1009

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. St. Mary's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Emmett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 23 (Day) 1 (Year)

7. AGE: 12 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: scholar
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: H. E. Emmett

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Rose Harrison

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. E. Emmett
(Address) Kendrick Ida.

15. Filed Feb 3 1920 Emma E. Brace Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Jan 31 1920, that I last saw h.r alive on Jan 31 1920, and that death occurred on the date stated above, at 11:55 P.M.

The CAUSE OF DEATH* was as follows:

Feb 1 1920

1 hr - Pneumonia (Broncho)

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Influenza - 3 days. Diabetes Mellitus

(Duration) 1 yrs. mos. ds.

(Signed) Edgar L. White M. D.

(Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kendrick — DATE OF BURIAL 19

20. UNDERTAKER: Dawson — ADDRESS Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28615
Registered No. 35-8

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. White's Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Dowling

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 50 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Baker
(Address) Clarkston Wn

15. Filed Feb 3 1920 Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1920, to Jan 27 1920 that I last saw him alive on Jan 27 1920 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) E L White M. D.
Jan 28 1920 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 1/31 1920

20. UNDERTAKER: C J Lossar — ADDRESS: Lewiston

La White.

...E. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28616

Registered No. 359

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

(No. White Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME K. L. Osmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	

6. DATE OF BIRTH Not Known (Month) (Day) 1872 (Year)

7. AGE 47 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Susan E Bruce

(Address) Lewiston

15. Filed Feb 3 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920 to Jan 29 1920 that I last saw h[illegible] alive on Jan 29 1920, and that death occurred on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:

Flu-Pneumonia (Lobar)

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. 14 ds.

(Signed) E. L. White M. D.

Jan 30 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston Ida — **DATE OF BURIAL** 2/2 1920

20. UNDERTAKER J Hassar — **ADDRESS** Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28617
Registered No. 366

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 2 E Bronco Hotel St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Pfannebecker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Single

6. DATE OF BIRTH: Oct (Month) 3 (Day) 1886 (Year)

7. AGE: 33 Yrs. 3 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sigourney Iowa

10. NAME OF FATHER: Chas Pfannebecker

11. BIRTHPLACE OF FATHER (State or Country): Iowa,

12. MAIDEN NAME OF MOTHER: Elvira Sager

13. BIRTHPLACE OF MOTHER (State or Country): Iowa,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Denver Pfannebecker
(Address) Sigourney Iowa

15. Filed Feb 3 1920 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1920, to Jan 30 1920 that I last saw h.... alive on Jan 20 1920 and that death occurred on the date stated above, at 9.30 A.M.
The CAUSE OF DEATH* was as follows:

Influenza (Pneumonia)

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Mitral Regurgitation
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) C G Broadock M. D.
Feb 1 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sigourney Iowa	Feb 1920

20. UNDERTAKER	ADDRESS
C J Vassar	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28618

Registered No. 351

1. PLACE OF DEATH

County of Nez Perces

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. 626 9th Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Clinton Sherar

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Widower

6. DATE OF BIRTH ? (Month) (Day) 1 (Year)

7. AGE 58 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kansas ~~Ill.~~

10. NAME OF FATHER John Sherar

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Garner

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A P Sherar
(Address)

15. Filed Feb 3 1920 Brom E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22, 1920, to Jan 28 1920 that I last saw h~~im~~er alive on Jan 28 1920, and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Flu Pneumonia
(Broncho)
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 8 ds.

(Signed) E L White M. D.
Jan 28 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston | DATE OF BURIAL 1/29 1920

20. UNDERTAKER Glasgow | ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28619
Registered No. 352

Registration District No. 96
Primary Registration District No. 1009

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. 705 - 15th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gayland Hunfred Skinner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M	W	Single (Write the word.)

6. DATE OF BIRTH: October (Month) 20 (Day) 1918 (Year)

7. AGE: 1 Yrs. 3 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Ralph J. Gayland Hunfred Skinner

11. BIRTHPLACE OF FATHER (State or Country) South Dakota

12. MAIDEN NAME OF MOTHER Ella Myrtle

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph J. Skinner
(Address) .....

15. Filed Feb 3 1920 Susan E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Jan 28 1920
that I last saw h.. alive on Jan 28 1920
and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:
Dm Illness a Followed by Watery Stools

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. 2 ds.
(Signed) C F Thomas M. D.
19 ..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	1/29 1920
20. UNDERTAKER C J Vassar	ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28620

Registered No. 353

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

(No. 1016 — 8th Ave St.)

Registration District No. 96

Primary Registration District No. 1009

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Dorothy Weisgerber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Single

6. DATE OF BIRTH: Nov (Month) 10 (Day) 1 (Year)

7. AGE: 3 Yrs. 2 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lewiston

10. NAME OF FATHER Ray J Weisgerber

11. BIRTHPLACE OF FATHER (State or Country) Lewiston

12. MAIDEN NAME OF MOTHER Viola G. Hendrickson

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ralph Weisgerber

(Address) Lewiston Idaho.

15. Filed Feb 3 1920 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25th 19 20, to Jan 27th 19 20, that I last saw h.r alive on Jan 27th 19 20, and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. C. Eggleston M. D.

19 ..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	1/28 1920
20. UNDERTAKER	ADDRESS
J. Vassar	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Gusano

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 28621
Registered No. 35-4

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 518 3rd Ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME U. G. King

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Single

6. DATE OF BIRTH: Feb (Month) 10 (Day) 1 (Year)

7. AGE: 18 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: a scholar
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: G. B. King

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: May Greenwood

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. B. King
(Address)

15. Filed Feb 3 1920 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920, to Jan 27 1920
that I last saw him alive on Jan 26 1920
and that death occurred on the date stated above, at 12 A. M.
The CAUSE OF DEATH* was as follows:

Flu Pneumonia.
(Contributory)

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. 6 ds.

(Signed) E. L. White M. D.
Jan 27 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Russell D | DATE OF BURIAL 19

20. UNDERTAKER: Wasson | ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2174
File No. 28622
Registered No. -1-

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Fronman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug. (Month) 14 (Day) 1899 (Year)

7. AGE: 20 Yrs. 5 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Okla homa

10. NAME OF FATHER: Henry Fronman

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Angeline Eddy.

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma, Angeline Eddy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Fronman
(Address) Miami - Okla.

15. Filed Jan. 17 1920 William R. Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1917, to Jan 16 1920, that I last saw h.. alive on Jan 15 1920, and that death occured on the date stated above, at 1.30 a. M.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration ..... yrs. 9 mos. ..... ds.
(Signed) Claude E. Sims M. D.
1/16 1920 (Address) Lapwai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 yrs. 9 mos. 10 days. In the State 7 yrs. 9 mos. 10 days
Where was disease contracted if not at place of death? Okla homa.
Former or usual residence Miami, Okla homa.

19. PLACE OF BURIAL OR REMOVAL: Lapwai Cemetery
DATE OF BURIAL: Jan. 17 1920.

20. UNDERTAKER: L. B. Walls.
ADDRESS: Lapwai Ida.

BYRD - YORK CO., PTRS. & BKBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28632

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147

Primary Registration District No. 67

File No. 2

Registered No. 24

1. PLACE OF DEATH.
County of Latah
City of Kendrick P.O. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Axel H. Karlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Sept. (Month) 3 (Day) 1896 (Year)

7. AGE: 23 yrs. 4 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid
(b) General nature of industry business, or dstablishment in which employed (or employer): ~

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Karl L. Karlson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Charlotta Ahmare

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Karl L. Karlson
(Address) Kendrick, Ida.

15.
Filed 1-24 1920 P. C. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-16 1920, to 1-22 1920, that I last saw h. alive on 1-16 1920, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 4 yrs. ~ mos. ~ ds.

Contributory (Secondary) ~
(Duration) ~ yrs. ~ mos. ~ ds.

1-24-20 (Signed) P. C. Faust M. D.
1-24 1920 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Dry Ridge Cem. | DATE OF BURIAL: 1-25 1920

20. UNDERTAKER ~ | ADDRESS ~

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28633 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Deary
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2147
Primary Registration District No. 67
(No. ....., ... St.)

File No. 2
Registered No. 25
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fredericke Schultz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 16 (Day) 1833 (Year)

7. AGE: 86 yrs. 6 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: H. W.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Lenz

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Gravey
(Address) Deary

15.
Filed 2-7 1920 P. B. Faus
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Unattended
Probably Influenza

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pine Crest Cem.
DATE OF BURIAL: 2-3 1920

20. UNDERTAKER: ✓
ADDRESS: ✓

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 28645
Registered No. 3410

1. PLACE OF DEATH.
County of .....
City of .....
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Lesley Calaway

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Jan (Month) 18 (Day) 1900 (Year)
7. AGE: 19 Yrs. 11 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): Wash
10. NAME OF FATHER: Thomas A. Calaway
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Adelade Dennis
13. BIRTHPLACE OF MOTHER (State or Country): Wash
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas A Calaway
(Address) Salmon
15.
Filed ..... 191....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 3 1919, to Jan 9 1919, that I last saw him alive on Jan 8 1919, and that death occured on the date stated above, at 1 30 M.
The CAUSE OF DEATH* was as follows:
Typhoid Pneumonia
(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. H. Parkinson M. D.
1919 (Address) Redmond Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Regan — DATE OF BURIAL ..... 191....
20. UNDERTAKER: Downing — ADDRESS Rolley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28646
Registered No. 27

1. PLACE OF DEATH.
County of Madison
City of Burton
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178

2. FULL NAME Margret C. Hill

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Mar. (Month) 27 (Day) 1843 (Year)

7. AGE: 77 yrs. 9 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Wm Gardner

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Genet Linnston

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt. G. Hill
(Address) Burton

15. Filed 1/11 1920 G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h~~e~~ alive on 1-9 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF ~~DEATH~~* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G G Espe M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton | DATE OF BURIAL: 1/12 1920

20. UNDERTAKER: John Phillips | ADDRESS: Rexburg

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. .... St.)

File No. 28648
Registered No. 293

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Madison
City of Sugar

2. FULL NAME Jose Cordova

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 3rd (Day) 1904 (Year)

7. AGE: 15 Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Day labor
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Pasquale Cordova

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Maxada Padilla

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Francisco Tavarez
(Address) Sugar City, Idaho

15.
Filed ..... 191.....
..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 16th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 4 1920, to January 16 1920, that I last saw h.im alive on January 15 1920 and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs ..... mos. ..... ds.

(Signed) W. B. Evans M. D.
19..... (Address) Sugar City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sugar City	1/17 1920
20. UNDERTAKER	ADDRESS
John Phillips	Rexburg

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho
City of Greencreek
(No. ....., ... St.)

Registration District No. 105
Primary Registration District No. 2183
File No. 28619
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Barbara F Hermes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 31 (Day) 1918 (Year)

7. AGE: 1 Yrs. 9 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Carl Hermes

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Theresa Kelsch

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John J. Kelsch
(Address) Greencreek

15. Filed Jany 6 1926 — H. Bosse, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 6 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-10 1925, to 1-6 1926, that I last saw h[illegible] alive on Jan 5 1926 and that death occured on the date stated above, at 2.0 A. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia following, Influenza Lung complications
(Duration) ..... Yrs. ..... mos. 2 5 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. 4 ds.

(Signed) J. D. Skinner M. D.
1-6 1926 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Greencreek Cemetery	Jan 7 1926
20. UNDERTAKER	ADDRESS
John J. Kelsch	Greencreek

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 28650
Registered No. 75

1. PLACE OF DEATH.
County of Idaho
City of Rose Ranch
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cyrus Conner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Mar. (Month) 6 (Day) 1900 (Year)

7. AGE: 19 Yrs. 10 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E. J. Conner.

11. BIRTHPLACE OF FATHER (State or Country): Washington.

12. MAIDEN NAME OF MOTHER: Sarah.

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. J. Conner
(Address) Pendleton, Oregon

15. Filed Jan 19 1920 — Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1920, to Jan 19 1920, that I last saw him alive on Jan 18 1920 and that death occured on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:
Acute Endocarditis following Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Webb M. D.
Jan 19 1920 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: J. Johnson — ADDRESS: Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 28651
Registered No. 74

1. PLACE OF DEATH.
County of Idaho
City of Stites
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ole G. Horde

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write which)
Male	White	Married

6. DATE OF BIRTH.
Mar (Month) 15 (Day) 1856 (Year)

7. AGE
64 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Norway

10. NAME OF FATHER
Ole Horde

11. BIRTHPLACE OF FATHER
(State or Country) Norway

12. MAIDEN NAME OF MOTHER
Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anna Horde
(Address) Stites

15.
Filed Jan 18 1920
J M Verbrugge
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Dropped dead at 8 15 a m without illness - or premonition

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) H W Whitworth M. D.
Jan 16 1920 (Address) Stites

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Stites
DATE OF BURIAL Jan 17 1920

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Kooskia
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106
Primary Registration District No. 2184
(No. ....., ... St.)

File No. 28653
Registered No. 78
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jerome Warren Crook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
March (Month) 19 (Day) 1855 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James Madison Crook

11. BIRTHPLACE OF FATHER (State or Country): Not - obtainable

12. MAIDEN NAME OF MOTHER: Sina Warren

13. BIRTHPLACE OF MOTHER (State or Country): Not - obtainable

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Emma Crook
(Address) Kooskia - Idaho

15.
Filed Jan 31 1920 J M Weberkuves Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1919 to Jan 31 1920
that I last saw h[illegible] alive on Jan 30 1920
and that death occurred on the date stated above, at 1:15 a M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Weberkuves M. D.
Jan 31 1920 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kooskia - Cemetery	Feb 1 1920

20. UNDERTAKER	ADDRESS
Geo Tremony	Kooskia Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 28054
(No. ..... St.)
Registered No. 77

1. PLACE OF DEATH.
County of Idaho
City of Stites
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victor P Lowell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 21 (Day) 1860 (Year)

7. AGE: 59 Yrs. 3 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Laura Lowell
(Address) Wife Stites Ida

15. Filed Jan 30 1920 J M Webb Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 28th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920, to Jan 28 1920, that I last saw him alive on Jan 28 1920, and that death occured on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:
Uraemic poisoning from
Chronic Brights fodlowing
an acute Pleurisy
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Acute Pleurisy
(Duration yrs. mos. 3 ds.
(Signed) H W Wentworth M. D.
Jan 7 1920 (Address) Stites

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Stites
DATE OF BURIAL: Jan 30 1920

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28655

Registered No. 76

1. PLACE OF DEATH.

County of Idaho

City of Kooskia

Registration District No. [illegible]

Primary Registration District No. [illegible]

(No. [illegible], [illegible] St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Humphill.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 22 (Day) 1860 (Year)

7. AGE: 59 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: David Humphill

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: no record

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John H. Humphill.

(Address) Kooskia, Idaho.

15. Filed Jan 27 1920

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24659

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to Jan 23 1920, that I last saw him alive on Jan 22 1920, and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J M Werbelmus M. D.

Jan 27 1920 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jaker Cemetery

DATE OF BURIAL: Jan 25 1920

20. UNDERTAKER: Lee Freeman

ADDRESS: Kooskia - Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

28656 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)

Registration District No. 116
Primary Registration District No. 2185
File No. 3
Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caroline Ahlin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. — (Month) — (Day) 1835 (Year)

7. AGE: 85 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Parsons
(Address) Aberdeen Ida

15. Filed Jan 12 1920 M Armstrong Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920, to Jan 11 1920, that I last saw her alive on Jan 11 1920, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M Armstrong M. D.
1-12 1920 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Aberdeen Ida
DATE OF BURIAL: 1-13 1920

20. UNDERTAKER: Friends
ADDRESS: —

FORM V. S. No. 5-25 M. 1-16-13

28657

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2155
File No. 3
Registered No. 24

1. PLACE OF DEATH.
County of Bingham
City of Sterling
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Valerian Heaney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Dec (Day) 17 (Year) 1918

7. AGE: 1 Yrs. / Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Sam Heaney

11. BIRTHPLACE OF FATHER (State or Country): Newfoundland

12. MAIDEN NAME OF MOTHER: Kate Meade

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sam Heaney
(Address) Sterling Idaho

15. Filed 1-27 1920 M McCrumm
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Jany (Day) 24 (Year) 1920

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920, to Jan 24 1920, that I last saw h[e] alive on Jan 23 1920 and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Rickets

(Duration) Yrs. 6 mos. ..... ds.
Contributory (Secondary) La Grippe
(Duration ..... yrs. ..... mos. 3 ds.

(Signed) M McCrumm M. D.
1-27 1920 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Aberdeen
DATE OF BURIAL: 1-27 1920

20. UNDERTAKER: Friends
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28659

Registered No. —

Registration District No. 121

Primary Registration District No. 2194.

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

(No. ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Henry Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 24 (Day) 1835 (Year)

7. AGE: 85 Yrs. 6 Mos. 18 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: S M Adams

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John L Adams

(Address) Riverside

15. Filed Jan. 10 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1919, to Jan 7 1920 that I last saw h[e] alive on Jan 7 1920 and that death occurred on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficency

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) F. L. Mitchell M. D.

1/7 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery — DATE OF BURIAL: 1-9 1920

20. UNDERTAKER: Blackfoot Undertaking Co — ADDRESS: Blackfoot

By Ed L Egli.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28661
Registered No. 4

Registration District No. 1211
Primary Registration District No. 1207

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. 467 North Shoup St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wealthy A Jordan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH. April (Month) 22 (Day) 1840 (Year)

7. AGE 79 Yrs. 9 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Del.

10. NAME OF FATHER Winn

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Drusella Taylor

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W G Jordan
(Address) Blackfoot Ida.

15. Filed Jan 13 1920 Mort E. Thompson Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 12 Th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15th 1919, to Jan 10th 1920, that I last saw h.. alive on Jan 10th 1920, and that death occured on the date stated above, at 12.0p M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Secondary
1st Attack (Duration) Yrs about 10 yrs mos ds.
Contributory (Secondary) age
(Duration yrs. mos. ds.
(Signed) J A Hampton M. D.
1/12 1920 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Morrisonville Del. DATE OF BURIAL ..... 191..

20. UNDERTAKER E J Peck ADDRESS Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 07
File No. 28662
Registered No. 6

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Mary Hughes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Feb. (Month) 20 (Day) 1871 (Year)

7. AGE: 48 Yrs. 11 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Nathan Calark

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Nancy Jane Calark

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles J. Hughes
(Address) Blackfoot Ida

15. Filed ..... 191 .....
Mrs Nalen E. Parker
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1919, to Jan 16 1920, that I last saw h alive on Jan 16 1920, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Brights disease

(Duration) 6 Yrs. — mos. — ds.

Contributory (Secondary) — — —

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. [illegible] D.

1/16 1920 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs. 7....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferncliff Cemetery — DATE OF BURIAL: Jan 19 1920

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. Each should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 28663
Registered No. 6

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot Idaho (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elaine Howe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 24 (Day) 1920. (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 5 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Blackfoot Idaho

10. NAME OF FATHER: Roy Howe

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jennie Taylor.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Roy Howe
(Address) Basin Ut. Box 66

15. Filed Jan 26 191[illegible] [illegible] Local Registrar

SMITH + YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1920, to Jan 25 1920, that I last saw her alive on Jan 25 1920, and that death occured on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:
Premature Birth.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.
Jan 25 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetary — DATE OF BURIAL: Jan 26 1920

20. UNDERTAKER: E. L. Peck — ADDRESS: Blackfoot

FORM V. S. No. 8-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121
Primary Registration District No. 2174

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28664
Registered No. 7

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mariam Steers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH
Dec (Month) 23 (Day) 1850 (Year)

7. AGE
69 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Salt Lake City Ut,

10. NAME OF FATHER James Blazzerd

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas J Steers
(Address) Shelley Ida.

15. Filed Jan 27 1920 Mrs Nalen E. Parker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 26 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 24 1920, to Jan 26 1920, that I last saw h.. alive on Jan 26 1920, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorhage
(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos A Davis M. D.
1-27 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Moreland Cemetery — DATE OF BURIAL Jan 29 1920

20. UNDERTAKER E. L. Eagle — ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28665
Registered No. 52

1. PLACE OF DEATH.
County of Kootenai
City of Harrison (No. ....., ... St.)
Registration District No. 126
Primary Registration District No. 2204
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna D. Bregg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH. Sept (Month) 19 (Day) 1867 (Year)
7. AGE: 52 Yrs. 4 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): N. J.
10. NAME OF FATHER: Joseph Dugard
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER: Anna Dugard
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Matilda Ketchum
(Address) Harrison Idaho
15. Filed Jan 26 1920 J. M. Fenney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 25 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1920, to ..... 191..., that I last saw him alive on Jan 25 1920, and that death occured on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
apoplexy
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Fenney M. D.
1-26 1920 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene — DATE OF BURIAL: 1-26 1920
20. UNDERTAKER: C. Conrad — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 66
Primary Registration District No. 2176
File No. 728666
Registered No. .....

1. PLACE OF DEATH.
County of Kalish
City of Borrill (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patrick Flynn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. March (Month) 17 (Day) 1839 (Year)
7. AGE: 81 Yrs. 11 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Night Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): Potlatch Lumber Co.
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country): Not Known
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. K. Parker
(Address) Borrill Idaho
15. Filed 2/26 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 25 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 18th 1920 to Feb 25 1920, that I last saw h~~im~~ alive on Feb 25 1920, and that death occured on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:

Purulent Bronchitis

(Duration) 20 Yrs. mos. ds.
Contributory (Secondary) Senility
(Duration yrs. mos. ds.

(Signed) F. C. Gibson M. D.
2/26 1920 (Address) Borrill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harvard Idaho — DATE OF BURIAL: 2/27 1920
20. UNDERTAKER: E. M. Irwin — ADDRESS: Palouse Wn

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

28667

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5

Registered No. .....

1. PLACE OF DEATH.

County of Latah

City of Bovill

Registration District No. 66

Primary Registration District No. 2146

(No. Bovill Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carlie Milton Hatfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 26 (Day) 1899 (Year)

7. AGE: 20 Yrs. 11 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Ewing L. Hatfield

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Minnie A Brooks

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Minnie Hatfield

(Address) Moscow Idaho

15.

Filed 2/18 1920

Mrs J C Gibson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 d 1920 to Feb 18 1920, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 9:20 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 13 ds.

(Signed) J C Gibson M. D.

2/18 1920 (Address) Bovill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos 13 days In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? Logging Camp

Former or usual residence Moscow Idaho

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho

DATE OF BURIAL: 1920

20. UNDERTAKER: Glen Grice

ADDRESS: Moscow Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - VOSE CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 28668

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah
City of Bovill
(No. Bovill Hospital St.)

Registration District No. 66
Primary Registration District No. 2146
File No. 2
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) – 17 (Day) – 189 (Year)

7. AGE: 28 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woods man
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Thompson

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Katharine Flansburg

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm John Thompson
(Address) Griswald Iowa

15.
Filed 2/12 1920
Mrs H. C. Gibson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) – 10 (Day) – 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3rd 1920, to Feb. 10th 1920, that I last saw him alive on Feb [redacted] 1920, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Myocarditis
(Duration ..... yrs. ..... mos. 8 ds.
(Signed) H. C. Gibson M. D.
2/10 1920 (Address) Bovill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 8 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? In Logging Camp
Former or usual residence Griswald Iowa

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho
DATE OF BURIAL 191

20. UNDERTAKER: H. E. Hunt
ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BKBS. 24658

28669

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah
City of Bovill
(No. Bovill Hospital St.)

Registration District No. 66
Primary Registration District No. 2146
File No. 1
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victor Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Not Known (Month) (Day) (Year)

7. AGE: 52 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Section Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Building logging road

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed 2/5 1920 Wm F.C. Gibson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 5th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 29 1920, to February 5 1920, that I last saw him alive on February 5 1920, and that death occured on the date stated above, at 6:30 a. M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia (Influenzal)
(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) F.C. Gibson M. D.
2/5 1920 (Address) Bovill, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 6 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Fernwood Ida
Former or usual residence Fernwood Idaho

19. PLACE OF BURIAL OR REMOVAL: St Maries Idaho
DATE OF BURIAL: 2/7 1920

20. UNDERTAKER: H E. Hurd
ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & RDRS. 24653

FORM V. S. No. 1-85 M. 1-15-13

CERTIFICATE OF DEATH.

28670

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Bovill

Registration District No. 66

Primary Registration District No. 2146

(No. ..... St.)

File No. 2

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George N. DeGroff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 30 (Day) 1869 (Year)

7. AGE: 51 Yrs. 3 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George N. DeGroff Jr.

(Address) Bovill Idaho

15. Filed 2/18 20 Mrs. K.C. Gibson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 11th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw him alive on Feb 11th 1920, and that death occured on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) K.C. Gibson M. D.

19..... (Address) Bovill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bovill Idaho	2/14 1920
20. UNDERTAKER	ADDRESS
E.M. Irwin	Palouse Wn.

N. B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—TYPE IS PREFERABLE. MARGIN RESERVED FOR BINDING. Certificate should be filled out in duplicate, and one copy should be sent to the Local Registrar of the district in which death occurred. Certificate should be signed by informant. Physician should state CAUSE OF DEATH in plain terms, so that it may be understood by the people. Instructions on back of certificate. Name of OCCUPATION is very important. See instructions on back.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

28671

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah
City of Bovill
(No. Bovill Hospital St.)

Registration District No. 66
Primary Registration District No. 2176
File No. X
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Martin Norsman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August (Month) 7 (Day) 1900 (Year)

7. AGE: 19 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Texas

10. NAME OF FATHER Peter A Norsman

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Anna Morstedt

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P. A. Norsman
(Address) Kendrick Idaho

15.
Filed 2/18 1920
Mrs. P. C. Gibson
Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920, to Feb 17 1920, that I last saw h... alive on Feb 17 1920, and that death occured on the date stated above, at 11:30 a M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Influenza

(Duration ..... yrs. ..... mos. 7 ds.

(Signed) P. C. Gibson M. D.

19..... (Address) Bovill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. ..... mos. 7 days. In the State..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Logging Camp

Former or usual residence Kendrick Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wild Rose Cemetary	2/19 1920

20. UNDERTAKER	ADDRESS
P. A. Norsman	Kendrick Ida.

28672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah — Registration District No. 66

City of Bovill — Primary Registration District No. 246

(No. Bovill Hospital St.)

File No. 6

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Earl Hageman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 18 (Day) 1900 (Year)

7. AGE: 19 Yrs. 5 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: C. A. Hageman

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Clara Voght

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. A. Hageman

(Address) Chewelah Washington

15. Filed 2/18 1920 Mrs. F. C. Gibson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920, to Feb 18 1920, that I last saw h-- alive on Feb 18 1920 and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Influenza

(Duration yrs. mos. 7 ds.

(Signed) F. C. Gibson M. D.

2/18 1920 (Address) Bovill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos. 7 days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death? Logging Camp

Former or usual residence Chewelah Washington

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho — DATE OF BURIAL: ...191...

20. UNDERTAKER: Ellen Price — ADDRESS: Moscow Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

6-7168 - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 68
County of Latah
City of Juliaetta (No. ....., ... St.)
Primary Registration District No. .....
File No. 28673
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Helfert

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 21 (Day) 1900 (Year)

7. AGE: 9 yrs. 10 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Latah Co. Ida

10. NAME OF FATHER: Geo Helfert.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mamie T. Jones

13. BIRTHPLACE OF MOTHER (State or Country): No. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. J. Jones
(Address) Palouse Wn

15. Filed 1-21 1920 R. H. Pepple Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1920, to Jan 20 1920, that I last saw her alive on Jan 19 1920 and that death occurred on the date stated above, at 11 9 M.

The CAUSE OF DEATH* was as follows:
Valvular Disease of Heart

abt
The (Duration) 2 yrs. — mos. — ds.
Contributory (Secondary) Inf Rheumatism
(Duration) — yrs. 6 mos. — ds.

(Signed) James H Kelly M. D.
Jan 20 1920 (Address) Kendrick Idaho

*(State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: Jan 23 1920

20. UNDERTAKER: Glen Price
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
File No. 28674
Registered No. .....

1. PLACE OF DEATH.
County of Custer
City of Macray
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kate Lemon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. 2 (Month) 3 (Day) 1889 (Year)

7. AGE: 31 Yrs. 0 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph Vanous.

11. BIRTHPLACE OF FATHER (State or Country): Bohemia

12. MAIDEN NAME OF MOTHER: Mary Ruzicka

13. BIRTHPLACE OF MOTHER (State or Country): Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. P. Richards
(Address) Macray, Idaho

15. Filed 2/25 192 5 Ross Mansfield Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/13 1920, to 2/17 1920, that I last saw h[illegible] alive on 2/17 1920 and that death occured on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) — Yrs. — mos. 5 ds.

Contributory (Secondary) Influenza

(Duration — yrs. — mos. 2 ds.

(Signed) F. P. Richards M. D.

19 (Address) Macray, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER | ADDRESS

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

28675

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
File No. 36
Registered No. 3176

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. General Hosp. St.)

2. FULL NAME Aline Chandler Trout

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug 25 1890 (Month) (Day) (Year)

7. AGE: 29 Yrs. 4 Mos. 21 ds.
IF LESS THAN 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Boyd S. Chandler

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: May Conner

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sidney H. Trout
(Address) Pocatello Idaho

15. Filed Jan 16 1920 O R Lloyd Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12 1920 to Jan. 15 1920
that I last saw her alive on Jan. 15 1920
and that death occurred on the date stated above, at 10.30 P. M.

The CAUSE OF DEATH* was as follows:
Gastric peritonitis
(Duration) .... Yrs. .... mos. 5 ds.
Contributory (Secondary) Ruptured appendix
(Duration) .... Yrs. .... mos. .... ds.

(Signed) .... M.D.
1/16 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. 24 hours days. In the State 1 yrs. 6 mos. .... days
Where was disease contracted if not at place of death?
Former or usual residence Ogden, Utah

19. PLACE OF BURIAL OR REMOVAL: Ogden, Utah — DATE OF BURIAL: Jan 18 1920

20. UNDERTAKER: A. L. McHan — ADDRESS: Pocatello

28676

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 30
Registered No. 3175

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 631 No 4 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 23 (Day) 1919 (Year)

7. AGE: Yrs. 0 Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: O. B. Williams

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: E. Williams

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. B. Williams
(Address) 631 No 4th

15. Filed Jan 14, 1920 O. B. Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 13 (Day) 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 13. 1920 to Jany 13 1920
that I last saw h[illegible] on Jany 13 1920,
and that death occurred on the date stated above, at 8:20 M.
The CAUSE OF DEATH* was as follows:
possibly pneumonia
Baby dead 1st time saw him
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. [illegible] Lyon M. D.
Jan 13 1920. (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] Cemetery — DATE OF BURIAL: 1/14 1920

20. UNDERTAKER: [illegible] Tucker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

STAR-TIMES CO., PRINTERS & BINDERS, BOISE 51083

28677

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2401
(No.) Fox Street (St.)

File No. 20
Registered No. 3174
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph E. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 7 (Day) 1844 (Year)

7. AGE: 75 Yrs. 7 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Stuttenburg Ger.

10. NAME OF FATHER: /

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Miller
(Address) Mc Cammon.

15. Filed Jan 12 1920 O B Steele Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 6 1920, to January 10 1920, that I last saw him alive on January 10 1920, and that death occurred on the date stated above, at 10 20 P. M.
The CAUSE OF DEATH* was as follows:
Cancer of Liver
(Duration) Yrs. 3 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. N. Lyman M. D.
Jan 11 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Cancer 2 Liver
Former or usual residence Mc Cammon Ida

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery | DATE OF BURIAL: 1/11 1920

20. UNDERTAKER: J. D. Walker ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28678 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Oxford
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. Pradmore St.)

File No. 31
Registered No. 3173
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Betty Adelia Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: February (Month) 27 (Day) 1861 (Year)

7. AGE: 58 yrs. 10 mos. 12 ds. IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or datablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Olof Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Betty Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Olof R. Olson Husband
(Address) Oxford Idaho.

15. Filed Feb 16 1920 O. B. Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1920 to Jan 9 1920 that I last saw h alive on Jan 8 1920, and that death occurred on the date stated above, at 5 20 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis with Hypertrophy & Decompensation
(Duration) 4 yrs. mos. ds.
Contributory (Secondary) Arthritis Deformans
(Duration) 28 yrs. mos. ds.
(Signed) J. R. Cutler M. D.
Jan 10 1920 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Oxford Idaho	Jan 12 1920
20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

28679

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

County of Bannock

Primary Registration District No. 2161

City of Pocatello (No. 324 So Joseph St.)

File No. 31

Registered No. 3172

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Infant

6. DATE OF BIRTH: January (Month) 2 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: Samuel Smith

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah.

12. MAIDEN NAME OF MOTHER: Flavia Sidwell

13. BIRTHPLACE OF MOTHER (State or Country): Junction Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Smith
(Address) Jerome Idaho

15. Filed Jan 6, 1920 O B Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920, to Jan 6th 1920, that I last saw him alive on Jan 6th 1920 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) W. M. D.

Jan 6 1920 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Idaho — DATE OF BURIAL: Jan 1920

20. UNDERTAKER: Johnson & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28680

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

County of Bannock

Primary Registration District No. 2104

City of Pocatello (No. 456 N. Hayes St.)

File No. 39

Registered No. 377

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theresa Josephine Foley

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept 23 (Month) (Day) 1901 (Year)

7. AGE: 18 yrs. 3 mos. 12 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Foley

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Hannah Cummins

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Foley
(Address): Pocatello Idaho

15. Filed Jan 7, 1920 O B Steed, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 5th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1919, to Jan 5 1920, that I last saw her alive on Jan 5 1920 and that death occurred on the date stated above, at 8 10 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency - Thickening of heart valves - (Organic)

(Duration) Several yrs. mos. ds.

Contributory (Secondary) Pulmonary Congestion or Hypostasis.

(Duration) yrs. mos. ds.

(Signed) J W Mahoney M. D.

1/7 1920 (Address) Pocatello, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Jan 8 1920

20. UNDERTAKER: Summers & Hall — ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS | YORK CO., PTRS. & BDRS. 15760

28681

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
(No. ....., ... St.)

File No. 30
Registered No. 3170

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bannock
City of Lava Hot Springs

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME D C Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	widower

6. DATE OF BIRTH.
not known — (Month) (Day) 1 (Year)

7. AGE
67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... day laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Texas

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thos Fallon
(Address) 757 Main East Twin Falls Ida

15. Filed Jan 27 1920 O R Green Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-31 1920, to 1-5 1920, that I last saw h[im] alive on 1-5 1920, and that death occured on the date stated above, at 2P M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. Ingleswith M. D.
1-27 1920 (Address) Lava Hot Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 7 days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? yes
Former or usual residence Twin Falls Ida

19. PLACE OF BURIAL OR REMOVAL Twin Falls, Ida — DATE OF BURIAL 1-8 1920

20. UNDERTAKER J E. Dei[illegible] — ADDRESS Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28682 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 30
Registered No. 3169

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. St. Anthony Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse William Hobson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: December 13 1919 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: J V Hobson

11. BIRTHPLACE OF FATHER (State or Country): Oxford

12. MAIDEN NAME OF MOTHER: Saphronia Hadley

13. BIRTHPLACE OF MOTHER (State or Country): Brigham City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. V. Hobson
(Address) Oxford

15. Filed Jan 2 1920 O. R. Deweese
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 28 1919 to Jan 2 1919 that I last saw h[e] alive on Jan 2 1919 and that death occurred on the date stated above, at 6a M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 8 ds.
(Signed) W. S. Downey M. D.
Jan 2 1919 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Swan Lake Ida
DATE OF BURIAL: Jan 4 1920

20. UNDERTAKER: Schumacher & Hall
ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 26689
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Della Lee Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
May (Month) 15 (Day) 1871 (Year)

7. AGE
48 Yrs. 8 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Towns Ville Mo

10. NAME OF FATHER: Elwood Buckworth

11. BIRTHPLACE OF FATHER (State or Country): X

12. MAIDEN NAME OF MOTHER: Malisa West

13. BIRTHPLACE OF MOTHER (State or Country): X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ina Ellis
(Address) Meridian

15. Filed Feb 8 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920, to Feb 7 1920, that I last saw h[illegible] alive on Feb 191[illegible], and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia, Bronchial

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Flu
(Duration ..... yrs. ..... mos. 7 ds.

(Signed) Talbert F. Neal M. D.
2-9 1920 (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian — DATE OF BURIAL: Feb 191[illegible]

20. UNDERTAKER: W. S. Hoaton — ADDRESS: Meridian

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28690

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28690

Registered No.

1. PLACE OF DEATH

County of Ada

City of Eastick

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11 Sutton

Primary Registration District No. 2013

(No. Eastick St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold Wilson Spangenberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	White	Married

6. DATE OF BIRTH: Jan 13 1892 (Month) (Day) (Year)

7. AGE: 28 Yrs. Mos. 19 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: W. H Spangenberg

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Jena A. Moulton

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leard E Spangenberg

(Address) 1012 N 22 St. Boise Ida

15. Filed Feb 5 1920 Allen A. Sutton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 4 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 29 1920 to Feb. 4 1920 that I last saw him alive on Feb. 4 1920 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

1. Pernicious Influenza
2. Pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. L. Sutton M. D.

Feb 5 1920 (Address) Meridian, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho | DATE OF BURIAL: Feb. 6 1920

20. UNDERTAKER: Summers Hub | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 28691
Registered No. ____

1. PLACE OF DEATH.
County of Ada
City of Meridian (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen E Voorhees

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 31 (Day) 1886 (Year)

7. AGE: 34 Yrs. ____ Mos. 4 ds.
IF LESS than 1 day how many ____ hrs. ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Ed Chamberlain

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: ____

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Voorhees
(Address) Meridian Idaho

15. Filed Feb 4 1920 Alice A Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st 1920, to Feb 3rd 1920, that I last saw her alive on Feb 2nd 1920 and that death occured on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Spanish Influenza
with Pneumonia

(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Carcinoma

(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) A C Dutton M. D.
19____ (Address) ____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Meridian Ida — DATE OF BURIAL: Feb 4 1920

20. UNDERTAKER: W S Mitton — ADDRESS: Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28693

Registered No. .....

1. PLACE OF DEATH.

County of Ada

City of Meridian

Registration District No. .....

Primary Registration District No. 2003

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James M. Grooms

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 4 (Day) 1855 (Year)

7. AGE 64 Yrs. 11 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. .....

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) New London Iowa

10. NAME OF FATHER Perry A Grooms

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Harriett Burkey

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo M Grooms

(Address) Meridian Idaho

15. Filed Feb. 27 1920 Alice A. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25-6pm. 1920, to Feb 25-6pm. 1920, that I last saw him alive on Feb 20 1920, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Spanish Influenza

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pernicious Anaemia

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Dutton M. D.

19..... (Address) Meridian Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: Feb 28 1920

20. UNDERTAKER: W S Mattin — ADDRESS: Meridian

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-19.

(9)

Pettenger

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. Soldiers Home Hospital St.)

File No. 20094

Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Lowell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Widower

6. DATE OF BIRTH

Jan — 1847
(Month) (Day) (Year)

7. AGE

79 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Veteran Civil War

(b) General nature of industry, business or establishment in which employed (or employer) **********

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry Krebs.

(Address) Boise Idaho

15. Filed Feb 2 1920 L. P. Kinnear Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Jan 29 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/ 1919, to 1/29 1920 that I last saw h alive on 1/28 1920, and that death occurred on the date stated above, at 6. A M.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

1/30 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — DATE OF BURIAL Boise Idaho

20. UNDERTAKER Summers & Krebs — ADDRESS Feb 1930

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 28595
Registered No. 12

1. PLACE OF DEATH
County of Ada
City of
If death occurs away from usual residence, give facts called for under special information.
(No.) 3 miles N of Boise

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph William Best

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Widower

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1848 (Year)

7. AGE: 71 Yrs. 3 Mos. 14 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: William Best

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Eliza Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Annie E Wrenshe
(Address) Boise Idaho R 7 Box 2.

15. Filed Feb 2 1920 L. O. Rhoades Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1920, to Jan 30 1920 that I last saw h.m alive on Jan 30 1920 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Senility.

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. Earl Hill M. D.

2/2/20 19... (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 2 19 20

20. UNDERTAKER: Summers & Trebs — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Pathenya

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2574

(No. Soldiers Home Hospital)

File No. 28696

Registered No. 13

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug. (Month) 26 (Day) 1831 (Year)

7. AGE: 84 Yrs. 5 Mos. 8 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Ellen White.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Rebecca Dickinson

13. BIRTHPLACE OF MOTHER (State or Country): Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Alice Goodall

(Address) Eagle Idaho

15. Filed Feb 4 1920 L. P. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/3 1920 to 2/3 1920 that I last saw h[illegible] alive on 2/3 1920 and that death occurred on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Tuttle M. D.

2/4 1920 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Feb. 6 1920

20. UNDERTAKER	ADDRESS
Summers & Kreb	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 28697
Registered No. 15

1. PLACE OF DEATH
County of Ada
City of Boise
(No. Near Fair Grounds St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Benton Lindsey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Mch - 5 - 1853 (Month) (Day) (Year)

7. AGE: 66 Yrs. 10 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: Stephen Lindsey

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Letha Ann Martin

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise, Idaho.

15. Filed Feb 5 1920 L. P. Gunnison
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb - 3 - 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1919, to Feb 3 1920
that I last saw him alive on Feb 2 1920
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Myocarditis
(Duration) yrs. 3 mos. ds.
(Signed) T. N. Bratton M. D.
2/3 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Portland, Ore.
DATE OF BURIAL 19

20. UNDERTAKER: W. McBratney
ADDRESS Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28698

Registered No. 94

1. PLACE OF DEATH

County of Ada

City of Boise

(No. Beacon St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. E. Rowe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1845 (Year)

7. AGE: 75 Yrs. Mos. 19 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Am.

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. L. Weiller

(Address) Boise R. #5

15. Filed Feb 5 1920 L. P. Benson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st 1920 to Feb 5th 1920 that I last saw h. him alive on Feb 3d 1920 and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Bronchiectasis - Oedema of Lungs -

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Bank M. D.

Feb 5 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/6 1920

20. UNDERTAKER: Schrader & Hidenfadt — ADDRESS: Boise

Back

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 2869
Registered No. 66932

1. PLACE OF DEATH

County of Ada
City of Ustick
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Spangenberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Jan (Month) 29 (Day) 1920 (Year)

7. AGE: ---- Yrs. ---- Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): **********

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Harold Spangenberg

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwin Healy
(Address) Boise, Idaho.

15. Filed Feb 12 1920 L. O. Gunnar
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 7th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30th 1919 to Jan 7 1920
that I last saw h... alive on Jan 6 1920,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
Pneumonia
Contributory (Secondary) Premature birth.
(Duration) ..... Yrs. ..... mos. ..... ds.
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. L. Stanton M. D.
2/10 1920. (Address) Meridian, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Feb 1920

20. UNDERTAKER: Summers & Krebs
ADDRESS: Boise? Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 28700
Registered No. 17

1. PLACE OF DEATH

County of Ada
City of Star
(No. 2½ miles east of Star, Ada Co. Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vernon D. McConnel.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH May 13 1918.
(Month) (Day) (Year)

7. AGE 1 Yrs. 9 Mos. — ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Boise, Idaho

10. NAME OF FATHER Roy McConnel

11. BIRTHPLACE OF FATHER (State or Country) Caldwell, Idaho.

12. MAIDEN NAME OF MOTHER Alma Carlson

13. BIRTHPLACE OF MOTHER (State or Country) Denver, Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. McBratney
(Address) Boise Ida Ho.

15. Filed Feb 16 1920 L. P. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10 1920, to Feb 13 1920, that I last saw him alive on Feb 13 1920, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Influenza.

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) J. Woodfield M. D.

2/13 1920. (Address) Empire Bldg Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	2/14 1920

20. UNDERTAKER	ADDRESS
H. McBratney	Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

28701

Registration District No. 4

Primary Registration District No. 4

File No. 18

Registered No.

1. PLACE OF DEATH

County of Ada

City of Meadows (or Village or Township) (N. 4 Miles W of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Steven Kudla

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1914 (Year)

7. AGE: 5 Yrs. 11 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Vancouver B. C.

10. NAME OF FATHER John S. Kudla

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Ruby Rogers

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John S Kudla
(Address) R. F. D. No 2. Boise Ida

15. Filed Feb 17 1920 L. O. Inman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 15 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920 to Feb 15 1920 that I last saw h.. alive on Feb 15 1920 and that death occurred on the date stated above, at 4 30 P.M.

The CAUSE OF DEATH* was as follows:

Fracture of base of Skull.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Springer M. D.

Feb 15 1920. (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Feb 17 20
20. UNDERTAKER	ADDRESS
Summers & Kreb	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

28702

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2004

File No. 19

Registered No. 20

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 9 E. 2nd St Barber St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leo Champagne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 10 (Day) 1919 (Year)

7. AGE: ____ Yrs. 2 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Yakima, Wash

10. NAME OF FATHER: Henry Champagne

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Hazel Greenwood

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H Champagne
(Address) Barber

15. Filed Feb 24 1920 R O Pierce Local Registrar

SVMS - YORK CO., PTRS. & SONS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1920 to Feb 24 1920, that I last saw him alive on Feb 23 1920, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) Malnutrition

(Duration) ... yrs. ... mos. ... ds.

(Signed) Fred Bauer M. D.

2/24 1920 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/24 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Dr. Bauer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28703
Registered No.

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. 110 E. Dannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ariel D. Lockhart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Jan 4 (Month) (Day) 1892 (Year)

7. AGE: 28 Yrs. Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: G. P. Kendall

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theodore Lockhart
(Address) Boise Idaho

15. Filed Feb 11 1920 — L. C. Forman, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920 to Jan 31 1920
that I last saw her alive on Jan 31 1920
and that death occurred on the date stated above, at 7 11 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) Yrs. mos. 9 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 11 ds.

(Signed) J. Toomey M. D.
2/2 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nyna Idaho — DATE OF BURIAL: Feb 3 1920

20. UNDERTAKER: Summers & Kreb — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28704

Registered No. .....

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1023, Fort St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen M Brandt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: March 25 1884 (Month) (Day) (Year)

7. AGE: 35 Yrs. 10 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: John Olsen

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Emma Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. Thalemann

(Address) 1023 Fort St,

15. Filed Feb 2 1920 L. O. Rhman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 31 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1920 to Jan 19 1920 that I last saw h.e.r alive on Jan 19 1920 and that death occurred on the date stated above, at 11 1/2 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 yrs. 2 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ralph Todd M. D.

2/1 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Feb 2 1920

20. UNDERTAKER: Summers Bros | ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

Frazier

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28105

Registered No. 87

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 4

(No. St Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George M. Carson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Widower

6. DATE OF BIRTH: Apr (Month) 26 (Day) 1848 (Year)

7. AGE: 71 Yrs. Mos. 9 ds. 3 — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Insurance Agent
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: George M. Carson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Nancy L. Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F M Carson
(Address) Boise Idaho

15. Filed Feb-2 1920 L. O. James Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-22 1920, to 1-29 1920, that I last saw h alive on Jan 28 1920, and that death occurred on the date stated above, at 1.30A M.

The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W L Frazier M. D.

2/2 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Jan 30 1920
20. UNDERTAKER	ADDRESS
Simmons & Webb.	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28706

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

Registration District No.

Primary Registration District No. 4th

(No. 1107 N. 8th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rollin G. Gregory

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July 4 (Month) — 1910 (Year)

7. AGE: 9 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: In School

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: R. D. Gregory

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: A. Virginia Jessee

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McF Bratney

(Address) Boise, Idaho.

15. Filed Feb 2 1920 L. O. Yeman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) — 1 (Day) — 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 24 1920, to Jan. 31 1920, that I last saw him alive on Jan. 31 1920, and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Bronchial Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Holverson M. D.

2/3 1920 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/3 1920

20. UNDERTAKER: W. McF Bratney — ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28707

Registered No.

Registration District No.

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel Cora Watkins Kozlay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: aug 16 1890
(Month) (Day) (Year)

7. AGE: 29 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kinston Ill.

10. NAME OF FATHER: John Watkins

11. BIRTHPLACE OF FATHER (State or Country): Am.

12. MAIDEN NAME OF MOTHER: Mat Stainabl

13. BIRTHPLACE OF MOTHER (State or Country): Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed McGuffin
(Address) Boise

15. Filed Feb 2 1920 L. P. Hunter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 1 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/26 1920, to 2/1 1920, that I last saw h[illegible] alive on 1/31 1920, and that death occurred on the date stated above, at 12:30 P M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) Fred A. Tibbitts M. D.

2/2 1920 (Address) Overland

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/3 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Pettenger

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 28708
Registered No. .....

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1109 N. 20 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George H Rust
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1882 (Year)

7. AGE: 38 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Attorney at Law
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Frank G. Rust

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H R Hubbard
(Address) Boise Ida

15. Filed Feb 2 1920 L. P. Thomas Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Jan 30 1920, that I last saw h.im alive on Jan 30 1920, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Influenza - followed by Pneumonia.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Emil Kiv M. D.
2/2/20 19 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Feb 1 1920
20. UNDERTAKER	**ADDRESS**
Summers & Kirk	Boise Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28109

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 515 S. 15 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martin Larson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec 25 1 (Month) (Day) (Year)

7. AGE: 82 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Larson

(Address) 616 16th St

15. Filed Feb 2 1920 L. R. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 31 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to Jan 29 1920 that I last saw h alive on Jan 24 1920 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Complications of diseases

(Duration) Yrs. mos. ds.

Contributory (Secondary) Nephritis

(Duration) yrs. mos. ds.

(Signed) O H Parker M. D.

2/2 1920 (Address) 308 McCarty

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Feb 3 1920

20. UNDERTAKER: Summers & Krebs | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25710

Registered No. 38

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 410 State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Emerson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: White

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: About 1859 (Month) (Day) (Year)

7. AGE: About 61 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): U. S. A

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): U S A

12. MAIDEN NAME OF MOTHER: a a

13. BIRTHPLACE OF MOTHER (State or Country): a a

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Schreiber

(Address) Boise

15. Filed Feb 11 1920

A. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 31 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from Jan 31 1920 to Feb 1st 1920 that I last saw h. 1 m. alive on Feb 1st 1920, and that death occurred on the date stated above, at 1 20 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of rectum

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. McCallum M. D.

2/2 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/5 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28711

Registered No. 59

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry E. Gibbin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 16 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: H B Gibbin

11. BIRTHPLACE OF FATHER (State or Country): My Cousin

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Caldwell

15. Filed Feb 3 1920 191.... L. O. Jones Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 2. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1920, to Feb 2nd 1920, that I last saw h[illegible] alive on Feb 2nd 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Double Pneumonia.
(only saw him when he died)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza & Measles.
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
19.... (Address) L. O. McCall

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian | DATE OF BURIAL ..... 191....

20. UNDERTAKER: W. B. Mather Meridian | ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6812

Registered No.

Registration District No.

Primary Registration District No.

(No. 901 Harrison Boulevard St.)

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Marie Downs Heine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Caucasian	Married

6. DATE OF BIRTH: April (Month) 21 (Day) 1889 (Year)

7. AGE: 30 Yrs. 9 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hazelton Pennsylvania U S a

10. NAME OF FATHER: Michael E. Downs

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary O'Rourke

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George F. Niklaus
(Address) 221 Overland Building Boise Idaho

15. Filed Feb 4 1920 L. P. Gunman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1920 to Feb 2 1920 that I last saw h~~er~~ alive on Feb 2 1920 and that death occurred on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia
following influenza

(Duration) ..... Yrs. ..... mos. 17 ds.

Contributory (Secondary) Pregnancy

(Duration) ..... yrs. 7 mos. ..... ds.

(Signed) M. H. Fullerman M. D.

2/3 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	2/4 1920

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	(Boise Idaho)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2813
Registered No.

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. 2724 Idaho St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William W. Carnes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Married (or Widowed)

6. DATE OF BIRTH
June 23 1848
(Month) (Day) (Year)

7. AGE
71 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Simon Carnes.

11. BIRTHPLACE OF FATHER (State or Country) Canada.

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S B McCabe
(Address) Boise

15. Filed Feb 4 1920 L. O. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. 3 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920 to Feb 3 1920
that I last saw h[illegible] alive on Feb 2 1920
and that death occurred on the date stated above, at 7.30 P.M.
The CAUSE OF DEATH* was as follows:
Influenzal Bronchio Pneumonia

(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) Chr Asthma
(Duration) yrs. mos. ds.

(Signed) Wm E Burke M. D.
2/3 1920 (Address) 410 Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Feb 8 1920

20. UNDERTAKER: Summers & Kebs. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28714
Registered No.

Registration District No.
Primary Registration District No.

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 1405 N. 15th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Vance Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married

6. DATE OF BIRTH May (Month) 30th (Day) 1867 (Year)

7. AGE 52 Yrs. 8 Mos. 3 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ills.

10. NAME OF FATHER John Vance

11. BIRTHPLACE OF FATHER (State or Country) Va.

12. MAIDEN NAME OF MOTHER Sarah Archer

13. BIRTHPLACE OF MOTHER (State or Country) Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruth Baker Hauser
(Address) 1405 N. 15th

15. Filed Feb 4 1920 L. O. Quinn Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 3rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to Feb 6 1920 that I last saw her alive on Feb 2 1920 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) Yrs. 2 mos. 5 ds.

Contributory (Secondary) Pulmonary abscess

(Duration) yrs. 7 mos. ds.

(Signed) C. W. Tate M. D.

2-5 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL MacKay, Idaho — **DATE OF BURIAL** 2/4 1920.

20. UNDERTAKER Schreiber & Sidenfaden — **ADDRESS** (Boise)

Titus

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Tallman

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2615
Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 423 S. 12 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William H. Fletcher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 2 (Day) 1919 (Year)

7. AGE: Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: Lloyd W. Fletcher

11. BIRTHPLACE OF FATHER (State or Country): Idaho,

12. MAIDEN NAME OF MOTHER: Hazel Peters

13. BIRTHPLACE OF MOTHER (State or Country): Baker City Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lloyd W Fletcher
(Address) 423 S. 12. St.

15. Filed Feb 5 1920 L. P. Hasman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1920 to Feb 3 1920 that I last saw him alive on Jan 15 1920 and that death occurred on the date stated above, at 1 1/2 M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. H. Tallman M. D.

2/5 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 5 1920

20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2016

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St. Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Jennie Pierce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH Mch - 31 - 1888
(Month) (Day) (Year)

7. AGE 31 Yrs. 10 Mos. 3 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wyo.

10. NAME OF FATHER P. J. Hines.

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Nellie Thirloway

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. J. Mason
(Address) Boise, Idaho

15. Filed Feb 5 1920 L. O. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 4 1920
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 19 1920 to Feby 4 1920 that I last saw h alive on Feby 1920 and that death occurred on the date stated above, at P M.

The CAUSE OF DEATH* was as follows:
Cardiac dilatation following Operation for Exophthalmic Goitre

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Hyperthyroidism

(Duration) 2 yrs. mos. ds.

(Signed) James L. Stewart M. D.

2/4 1920 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain Home, Idaho DATE OF BURIAL 2/7 1920

20. UNDERTAKER W. McBratney ADDRESS Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M, 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. _____
Primary Registration District No. 1004
File No. 28717
Registered No. _____

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. 109 Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frances A. Carson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married,
6. DATE OF BIRTH: July 1 (Month) (Day) 1843 (Year)
7. AGE: 76 Yrs. 7 Mos. 0 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): ____
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: Constant Abbot.
11. BIRTHPLACE OF FATHER (State or Country): New Hampshire.
12. MAIDEN NAME OF MOTHER: Ruby Gillette
13. BIRTHPLACE OF MOTHER (State or Country): Vermont.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lola E. Hill
(Address) 1309 N 5-th
15. Dec 11, 1920 Filed 19____
A. P. Herman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 1 (Month) (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1920, to Feb 1 1920, that I last saw her alive on Feb 1 1920, and that death occurred on the date stated above, at 12 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ____ Yrs. ____ mos. 10 ds.
Contributory (Secondary) Influenza
(Duration) ____ yrs. ____ mos. 10 ds.
(Signed) R E Shurtz M. D.
2/5 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Feb 4 1920
20. UNDERTAKER: Summers & Krebs. ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Springer

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2878

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 110 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. Frank Cleveland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Feb (Month) 4 (Day) 1875 (Year)

7. AGE: 45 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electric fireman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: R. L. Cleveland

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Salome J Davis

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R L Cleveland
(Address) R R No 2 Boise Idaho

15. Filed Feb 5 1920 L. O. Thomas Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1920 to Feb 4 1920 that I last saw h... alive on Feb 4 1920 and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:

Shock following accidental injury.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Springer M. D.

Feb 4 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Idaho — DATE OF BURIAL: Feb 8 1920

20. UNDERTAKER: Summers Kelly — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 004
File No. 28719
Registered No. .....

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 611 Grove St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John R Rhodewald
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1867 (Year)

7. AGE: 53 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B Butler
(Address) Boise Idaho

15. Filed Feb 5 1920 L. P. Spence
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Feb 3 1920 to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 7A M.
The CAUSE OF DEATH* was as follows:

Valvular Heart trouble

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E Summers Coroner
2/5 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Feb 7 1920

20. UNDERTAKER: Summers & Reed
ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 208 Bannock St.)

File No. 2820

Registered No. 7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Lucille Folsom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 4 1917 (Month) (Day) (Year)

7. AGE: 2 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Louis L Folsom

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Charlotte A. Officer

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L P Folsom

(Address) 208 Bannock St. Boise

15. Filed Feb 5 1920 L. P. Quinn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 5 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to Feb 5 1920

that I last saw her alive on Feb 5 1920

and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Haemorrage bowels - as complication Pertussis and Influenza.

(Duration) Yrs. mos. ds.

Contributory (Secondary) Pertussis Influenza

(Duration) yrs. mos. ds.

(Signed) R. E. Shuntz M. D.

Feb 5 1920 (Address) R. E. Shuntz

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery. DATE OF BURIAL: Feb 6 1920.

20. UNDERTAKER: Summers & Keb. ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 1003
File No. 2872
Registered No. 71

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 744 Warm Springs St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cynthia A. Mann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: August 9 (Month) (Day) 1853 (Year)

7. AGE: 66 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: William H Pease

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Letitia A Cornell

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. A. Pease
(Address) Powell Wyoming

15. Filed Feb 8 1920 L. C. Summers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to Feb 6 1920, that I last saw her alive on Feb 6 1920, and that death occurred on the date stated above, at 11 a. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) T. N. Braxton M. D.

Feb 7 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 8 1920

20. UNDERTAKER: Summers & Kirks — ADDRESS: Boise Id

Tallman

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 25722
Registered No. 7

1. PLACE OF DEATH
County of Ada
City of Boise
(No. St. Alphonsus Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rhuea C. Wheeler.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.): Widow

6. DATE OF BIRTH: Feby 2 (Month) (Day) 1839 (Year)

7. AGE: 81 Yrs. — Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Nathaniel Beardsley.

11. BIRTHPLACE OF FATHER (State or Country): Connecticut

12. MAIDEN NAME OF MOTHER: Beardsley

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) L. M. Wheeler

15. Filed Feb 11, 20 19..... A. B. Forman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 5 1920 to Feb 9 1920 that I last saw her alive on Feb 8 1920 and that death occurred on the date stated above, at 3:15 A.M.

The CAUSE OF DEATH* was as follows:
Fractured femur

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D. Tallman M. D.
2/9 1920. (Address) Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Western Nebraska — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Summers & Krebs. — ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 23723

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St. Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mazle M. Marker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH: Dec (Month) 8 (Day) 1905 (Year)

7. AGE: 14 Yrs. 1 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Andrew Marker

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ellen Lindsay

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Marker
(Address) 604 So. 15th St.

15. Filed Feb 11, 1920 19..... L. O. Forman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr (Month) 7 (Day) 1920 (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1920 to Feb 7 1920, that I last saw her alive on Feb 7 1920, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 4 ds.

2/9 1920 (Signed) L. O. Forman M. D.

(Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28725

Registered No. 75

1. PLACE OF DEATH

County of Ada

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 1608 N. 7th St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emily C. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH Dec – 23 – 1864
(Month) (Day) (Year)

7. AGE 55 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Dont Know.

11. BIRTHPLACE OF FATHER (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Dont Know.

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McBratney.

(Address) Boise Idaho

15. Filed Feb 9 1920 L. O. Pence
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb – 6 – 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1919, to Feb 5th 1920, that I last saw her alive on Feb 4 1920, and that death occurred on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows:

Progressive Paralysis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R & S Lunt M. D.

2/7 1920 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — **DATE OF BURIAL** 2/9 1920

20. UNDERTAKER W. McBratney — **ADDRESS** Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28726
Registered No.

1. PLACE OF DEATH
County of Ada.
City of Boise.
(No. 816 Franklin St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Murray.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb 8 1920 (Month) (Day) (Year)

7. AGE: Still Born Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: T. D. Murray.

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Mary Pearl Hoss.

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McFarland
(Address) Boise Idaho.

15. Filed Feb 9 1920 L. R. Evans Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 8 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/8 1920, to 2/8 1920
that I last saw h... alive on 2/8 1920
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) F. H. Smith M. D.
2/8 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/9 1920
20. UNDERTAKER: W. McFarland — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28727

Registered No. 77

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert O. McGrath

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 15 (Day) 1877 (Year)

7. AGE: 42 Yrs. 9 Mos. 24 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Thomas W. Grath

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Louisa Grier

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Flora Brashears

(Address) Boise Ida.

15. Filed 19

L. B. Forman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1920, to Feb 7 1920, that I last saw h[illegible] alive on Feb 7 1920, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James L. Clemmons M. D.

2/10 1920 *(Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Ada Co.

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: 2/11 1920

20. UNDERTAKER: Schreiber & Siebenlist — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28728

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1215 W. Spring ave St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hosea Bradford Eastman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: November 21st, 1835 (Month) (Day) 1 (Year)

7. AGE: 84 Yrs. 3 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Banker and General Manager

(b) General nature of industry, business or establishment in which employed (or employer): Boise Art. Hot & Cold Water Company

9. BIRTHPLACE (State or Country): New Hampshire

10. NAME OF FATHER: Caleb Eastman

11. BIRTHPLACE OF FATHER (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Tabitha Aldredge

13. BIRTHPLACE OF MOTHER (State or Country): New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. S. Parkhurst

(Address) Boise, Idaho.

15. Filed Feb 21 1920

L. A. Thomas
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 10th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Feb 10 1920

that I last saw h..... alive on Feb 10 1920

and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Mit Bulbar paralysis.

(Duration) 6 Yrs. ..... mos. 2 ds.

Contributory (Secondary) Senile

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) James L. Edmonds M. D.

2/17 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	2/12 1920
20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise Ida

Dr. Stewart

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Buck

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28729

Registered No. 82

Registration District No. 2

Primary Registration District No. 1004

1. **PLACE OF DEATH**

County of Ada

City of Boise

(No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Umeda

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb 11 1920 (Month) (Day) (Year)

7. AGE: ....Yrs....Mos. 5 ds.

IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: H. Umeda

11. BIRTHPLACE OF FATHER (State or Country): Japan.

12. MAIDEN NAME OF MOTHER: H. Kawamata

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. Umeda

(Address) 620 Main st

15. Filed Feb 17 1920 Baird L. D. Gunn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 15th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11th 1920, to Feb 15th 1920 that I last saw h.. alive on Feb 14th 1920 and that death occurred on the date stated above, at 3 AM

The CAUSE OF DEATH* was as follows: Malformation

....(Duration) ....Yrs....mos....ds.

Contributory (Secondary)....

....(Duration) ....Yrs....mos....ds.

(Signed) John Buck M. D.

Feb 16 1920. (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence....

19. PLACE OF BURIAL OR REMOVAL: County Cemetery. DATE OF BURIAL: Feb 16 1920

20. UNDERTAKER: Summers & Kirk ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25730

Registered No. 83

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1604

(No. 400 6. Warm Springs Ave.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James A. W. Leod

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 22 1845 (Month) (Day) (Year)

7. AGE: 74 Yrs. 9 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laundryman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: John W. Leod

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary ?

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Mrs A. W. Leod Boise

15. Filed Feb. 17 1920 L. O. Thomas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 14 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1919, to Feb 14 1920, that I last saw him alive on Feb 14 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) T. N. Braxtan M. D.

Feb 16 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/17 1920

20. UNDERTAKER: Schreiber & Hidenbrand — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28731

Registered No. 84

Registration District No. 2

Primary Registration District No. 1004

1. **PLACE OF DEATH**

County of Ada

City of Boise.

(No. 744 Warm Springs Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Mary Fritzer

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: F.

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word.): Single

6. **DATE OF BIRTH**: (Month) (Day) 1906 (Year)

7. **AGE**: 14 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer): —

9. **BIRTHPLACE** (State or Country): Idaho.

10. **NAME OF FATHER**: C. N. Fritzer

11. **BIRTHPLACE OF FATHER** (State or Country): Unknown

12. **MAIDEN NAME OF MOTHER**: Unknown

13. **BIRTHPLACE OF MOTHER** (State or Country): Unknown.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) John W Fleiner

(Address) 744 W. S. C.

15. Filed Feb 19 1920 L. P. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Feb (Month) 16 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Feb 4 1920, to Feb 16 1920, that I last saw her alive on Feb 16 1920, and that death occurred on the date stated above, at 5.30 P.M.

The **CAUSE OF DEATH*** was as follows:

Influenza

(Duration) Yrs. mos. 12 ds.

Contributory (Secondary): Pneumonia.

(Duration) yrs. mos. 2 ds.

(Signed) T. N. Bratton M. D.

Feb 18 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Feb 18 1920.
20. UNDERTAKER	ADDRESS
Summers & Eells.	Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28732
Registered No. 85

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 1419 W Jefferson St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilhelmina A Schneider

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	White	~~Write the Word~~ Widow

6. DATE OF BIRTH: Nov 29 (Month) 1836 (Day) (Year)

7. AGE: 83 Yrs. 2 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Franz Koenig.

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Augusta Bunzino

13. BIRTHPLACE OF MOTHER (State or Country): France.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Amalia Holverson
(Address) 1419 W Jeff St

15. Filed Feb 19 1920 L. O. Lyman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Feb 15 1920; that I last saw h.. alive on Feb 15 1920; and that death occurred on the date stated above, at 12 00 M.
The CAUSE OF DEATH* was as follows:
Paralysis.
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Paralysis
(Duration) ..... yrs. ..... mos. 2 ds.
(Signed) H. M. Holverson M. D.
Feb 15 1920 (Address) 517 Empire

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenwood Cem. DATE OF BURIAL: May 1 1920
20. UNDERTAKER: Summers & Krebs ADDRESS: Boise Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28733

Registered No. 86

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1312 Grove St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lais Maria Noble

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH Feb 4 1920 (Month) (Day) (Year)

7. AGE Yrs. Mos. 14 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ada. Ida

10. NAME OF FATHER G. E. Noble

11. BIRTHPLACE OF FATHER (State or Country) Floyd Co. Iowa

12. MAIDEN NAME OF MOTHER Agnes Cronin

13. BIRTHPLACE OF MOTHER (State or Country) Butler Co. Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. E. Noble

(Address) Boise Ida.

15. Filed Feb 19 1920 L. P. Quinn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 18 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1920, to Feb 18 1920 that I last saw her alive on Feb 18 1920 and that death occurred on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P P French M. D.

Feb 18 1920 (Address) 417 Overland Bldg. Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL St Johns cemetery | **DATE OF BURIAL** 2/19 1920

20. UNDERTAKER Schreiber & Sidenfaden | **ADDRESS** Boise Ida

Dr. French

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28734

Registered No. 88

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loulla M. Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 5th (Day) 1873 (Year)

7. AGE: 46 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penna

10. NAME OF FATHER: Mr C K. McMichael

11. BIRTHPLACE OF FATHER (State or Country): Penna

12. MAIDEN NAME OF MOTHER: Mary Wingard

13. BIRTHPLACE OF MOTHER (State or Country): Penna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. M. Thompson

(Address) Caldwell, Idaho

15. Filed Feb 20 1920 L. P. Penn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 20th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1920, to Feb 20 1920, that I last saw her alive on Feb 20 1920 and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage & resulting hemiplegia 4½ Weeks ago.

Immediate Cause Edema of Lungs

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCall M. D.

2/20 1920 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos. 3 days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence: Caldwell Idaho

19. PLACE OF BURIAL OR REMOVAL: Caldwell Idaho — DATE OF BURIAL: 2/20 1920

20. UNDERTAKER: Schreiber & Sidenfaden (Boise) — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28735

Registered No. 89

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orlan Otis Morris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH Jan 10th 1920
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. 39 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Boise. Idaho

10. NAME OF FATHER Otis Morris

11. BIRTHPLACE OF FATHER (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Olive Kehn

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Otis Morris

(Address) Warren. Idaho.

15. Filed Feb 20 1920 L. O. James Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 19 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6th 1920, to Feb 19 1920, that I last saw him alive on Feb 19 1920, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. R. Nungesser M. D.

2/20/19 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Warrens Idaho

19. PLACE OF BURIAL OR REMOVAL Harris Hill Cemetery — **DATE OF BURIAL** 2/21 1920

20. UNDERTAKER Schreiber & Sidenfaden — **ADDRESS** (Boise)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 28736
Registered No. 90

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1017 N. 20. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Janet Rhodes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 21 (Day) 1873 (Year)

7. AGE: 46 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: James F. Wright

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mercie Skinner

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Rhodes
(Address) 1017 N. 20th

15. Filed Feb 20 1920 L. D. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27 1920, to Feb. 17 1920
that I last saw her alive on Feb 17 1920,
and that death occurred on the date stated above, at 7.40 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary)
.....(Duration) .....yrs.....mos.....ds.

(Signed) E. W. Kingsbury M. D.
Feb. 19 1920 (Address) 404-405 Idaho Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: Summers & Kreb — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28737
Registered No. 91

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 1407 N. 7th St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary C Staley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Jan 20 (Month) (Day) 1852 (Year)

7. AGE: 68 Yrs. 1 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Abram Stale

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Phebe Wells

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. M. Staley
(Address)

15. Filed Feb 21 1920 L O Jamison Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1920, to Feb 20 1920
that I last saw her alive on Feb 20 1920
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) ..... Yrs. ..... mos. 17 ds.
Contributory (Secondary) Pleuritic exudate
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) F. N. Bastian M. D.
Feb 21 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho | DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: Summers & Cook | ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28738

Registered No. 94

1. PLACE OF DEATH

County of Ada

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 711 No 20 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ray Harlan Kahl.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH June 25 1919
(Month) (Day) (Year)

7. AGE 0 Yrs. 7 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Arthur L. Kahl.

11. BIRTHPLACE OF FATHER (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Goldie Eagles.

13. BIRTHPLACE OF MOTHER (State or Country) Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. L. Kahl

(Address) 711 N. 20th St. Boise

15. Filed Feb 27 1920 L P Foreman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 23 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1920 to Feb 23 1920 that I last saw him alive on Feb 22 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza & Whooping Cough.

(Duration) Yrs. 1 mos. 6 ds.

Contributory (Secondary) Acute Dilitation of Heart.

(Duration) yrs. mos. 2 ds.

(Signed) T. N. Brattan M. D.

Feb 23 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Feb 24 1920
20. UNDERTAKER	**ADDRESS**
Summers & Hebb.	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 28739
Registered No. 95

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 310 Washington St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Claud Oliver Diers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Jan (Month) 26 (Day) 1920 (Year)
7. AGE: ... Yrs. 1 Mos. — ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Boise Ida
10. NAME OF FATHER: Cecil Diers
11. BIRTHPLACE OF FATHER (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Lola Ellsworth
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Cecil H. Diers
(Address) Boise
15. Filed Feb 26 1920 L. O. Pierce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 25 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1920 to Feb 26 1920, that I last saw h— alive on Feb 25 1920 and that death occured on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:
Mal nutrition
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Premature birth
(Duration) ... yrs. ... mos. ... ds.
(Signed) R E S Hurt M. D.
2/26 1920 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/26 1920
20. UNDERTAKER: Schreiber & Hidenfeldem Shultz — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28740

Registered No. 96

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 2119 N. 16th St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

2. FULL NAME George Vivian Frazier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: March 21 1885 (Month) (Day) (Year)

7. AGE: 35 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: Geo. Frazier

11. BIRTHPLACE OF FATHER (State or Country): N. York

12. MAIDEN NAME OF MOTHER: Alida Maybee

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. J. Frazier

(Address) Eagle R.D.1

15. Filed Jan 29 1920

A. E. Jemmon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920 to Jan 29 1920 that I last saw h— alive on Jan 23 1920, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... Yrs. ... mos. 7 ds.

Contributory (Secondary) Influenza

(Duration) ... yrs. ... mos. 10 ds.

(Signed) R E Shuntz M. D.

Jan. 30 1920 (Address) R E Shuntz

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 1/2 1920

20. UNDERTAKER: Gilmore & Hildenbrand — ADDRESS: Boise

Shuntz

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 28741
Registered No. 97

1. PLACE OF DEATH
County of Ada
City of Boise
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marian Reed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb 26 1920 (Month) (Day) (Year)

7. AGE: Twelve Hours — Yrs. ... Mos. ... ds.
IF LESS than 1 day how many 12 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER J P Reed

11. BIRTHPLACE OF FATHER (State or Country) Buccaline Iowa

12. MAIDEN NAME OF MOTHER Ella E Breshears

13. BIRTHPLACE OF MOTHER (State or Country) Polk Co Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Feb 27 1920 L A Foreman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 26 1920, to Feby 27 1920, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Spontaneous birth

..... (Duration) ..... Yrs. ..... mos. / ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jessie A Adams M. D.
19.... (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton Ida — DATE OF BURIAL: Feb 28 1920

20. UNDERTAKER: Wm McBratney — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28742
Registered No.

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1002
(No. 1711 Washington St St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June 23 (Month) (Day) 1867 (Year)

7. AGE: 52 Yrs. 7 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): 7

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Franz Anderson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A C Hansen
(Address) 1304 E. Jefferson

15. Filed Feb 2 1920 L. P. Rimmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1919 to Jan. 30 1920 that I last saw h.r alive on Jan. 30 1920 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Bronco Pneumonia
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Dr C M Kingsbury M. D.
19 (Address) 404-405 Idaho Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Feb 2 1920
20. UNDERTAKER: Schuetz & Liebsch — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28744 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31
Registered No. 3216

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2 0
(No. St. Anthony Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Georgia Barger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 15th, 1888
(Month) (Day) (Year)

7. AGE: 31 Yrs. 10 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: George Wright

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Mayra Chester

13. BIRTHPLACE OF MOTHER (State or Country): Richmond

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. W. Barger
(Address) Riverdale Idaho

15. Filed Feb 25, 1920 O. B. Cook Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby. 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 20 1920 to Feby 24 1920 that I last saw h[illegible] alive on Feby 24 1920 and that death occurred on the date stated above, at 6:30 M.

The CAUSE OF DEATH*, was as follows:
Nephritis
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Moseley M. D.
Feby 25 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverdale Idaho — DATE OF BURIAL: Feb 27 1920
20. UNDERTAKER: Schumacher & Ford — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

DISINTERMENT PERMIT

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Georgia Barger

now lying buried in Newdale Cemetery, in the City or Town of Newdale

County of Fremont State of Idaho, who died on the ____ day of Feb, 1___, Aged 32 years ____ months

____ days, the cause of death being Puss in kidney and not directly or indirectly by diphtheria;(membranous croup);scarlet fever;smallpox;leprosy;asiatic cholera;typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

_____ attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Private conveyance
private or railway conveyance

to Teton Cemetery in the City or Town of Teton County of Madison

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Fremont it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho,

permit issued to:

this 10th day of Oct, A.D. 1957.

W M Bass

Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City,

Town or County of _____ State of Idaho, this _____ day of _____ 19____.

_____

Health Officer

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28745

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31

Registered No. 3215

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. ..... St.)

2. FULL NAME Unknown

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) unknown

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tupper.

(Address) Dyst Coroner.

15. Filed Feb 25, 1920 J. B. Steely
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Suicide by Hanging.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John A Tupper D. M. D.

2-25 1920 (Address) Acting Coroner

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello, Ida.	2-25 1920
20. UNDERTAKER	**ADDRESS**
Marker.	Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28746 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. 354 So Grant St.)

File No. 31
Registered No. 3214
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fern Thora Hancock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Infant

6. DATE OF BIRTH
November 15 1919
(Month) (Day) (Year)

7. AGE
— Yrs. 3 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Pocatello Idaho

10. NAME OF FATHER
N. F. Hancock

11. BIRTHPLACE OF FATHER
(State or Country) Downey Ida

12. MAIDEN NAME OF MOTHER
Anna Jorgensen

13. BIRTHPLACE OF MOTHER
(State or Country) Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. F. Hancock
(Address) 354 - So Grant.

15. Filed Feb 25 1920 O. B. Steely
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1920, to Feb 24 1920
that I last saw her alive on Feb 24 1920
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) — Yrs. — mos. 15 ds.
Contributory (Secondary) Influenza
(Duration) — yrs. — mos. — ds.
(Signed) J. M. Day M. D.
2/25 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Central Idaho	Feb 25 1920
20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

28748

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2 61
File No. 31
Registered No. 3212

1. PLACE OF DEATH
County of Bannock
City of McCammon
(No. Pershing South Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olive Gittins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August (Month) 29 (Day) 1902 (Year)

7. AGE: 17 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer): Student in High School

9. BIRTHPLACE (State or Country): McCammon Idaho (U.S.A.)

10. NAME OF FATHER: Edwin Gittins Sr

11. BIRTHPLACE OF FATHER (State or Country): Mold North Wales England

12. MAIDEN NAME OF MOTHER: Mary Marble

13. BIRTHPLACE OF MOTHER (State or Country): Brigham City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. W. Gittins
(Address) McCammon, Idaho

15. Filed Feb 26 1930 O. B. Steely
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1930, to Feb 23 1930, that I last saw him alive on Feb 22 1930, and that death occurred on the date stated above, at 5:10 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 22 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Hartwig M. D.
2-23 1930 (Address) McCammon.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Denny Utah — DATE OF BURIAL: Feb 25 1930

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28749

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2

File No. 31

Registered No. 321

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. 650 West Bridge St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Opal Killian.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: November 11 (Month) (Day) 1918 (Year)

7. AGE: 1 Yrs. 5 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Boy

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot. Idaho

10. NAME OF FATHER: William P. Killian

11. BIRTHPLACE OF FATHER (State or Country): Glenwood Utah

12. MAIDEN NAME OF MOTHER: Verena Wright

13. BIRTHPLACE OF MOTHER (State or Country): Whiting Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William P. Killian

(Address) Pocatello Idaho

15. Filed Feby 21 1920 J. R. Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 20 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Feb 20 1920, that I last saw h.. alive on Feb 20 1920, and that death occurred on the date stated above, at 930 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial
complication Emfysema

(Duration) ..... Yrs. ..... mos. 18 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carl W Clark M. D.

2/ 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot — DATE OF BURIAL: Feb 1920

20. UNDERTAKER: [illegible] — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28750

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

County of Bannock

Primary Registration District No. 2 01

City of Pocatello (No. General Hospital St.)

File No. 31

Registered No. 32

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pearley Hall.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: Was born 29 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or datablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: W. B. Hall

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Mary E Hall

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Silas Hall
(Address) No Second Ave.

15. Filed Feb 22 1920 O Bates Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 2 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 20 1920, to Feby 20 1920 that I last saw h[illegible] alive on Feby 20 1920 and that death occurred on the date stated above, at 9 00 M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Primary)

(Duration) yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Ross Wallace M. D.

Feby 23 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morland Idaho — DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 54 — 28751

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock — Primary Registration District No. 26 — File No. 3

City of Pocatello — (No. 424 — So Johnson St.) — Registered No. 3209

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Gertrude Faith

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: August 8 1867 (Month) (Day) (Year)

7. AGE: 52 yrs. 6 mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Clayburn Owens

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Lizzie Darting

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Hunt Jr.
(Address) 424 — So Johnson.

15. Filed Feb 26 1920 O B Steed, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 19 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1920 to Feb 19 1920 that I last saw her alive on Feb 19 1920 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma Cervix

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) General debility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Kay, M. D.
2/20 1920 (Address) Pocatello, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Fun — DATE OF BURIAL: Feb 23 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

28752

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
File No. 31
Registered No. 3208

1. PLACE OF DEATH.

County of Bannock
City of Pocatello
(No. Tamarack St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sherman Hall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH. March 11 1908
(Month) (Day) (Year)

7. AGE 11 Yrs. 10 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Floyd Co -

10. NAME OF FATHER W. B. Hall

11. BIRTHPLACE OF FATHER (State or Country) Floyd Co

12. MAIDEN NAME OF MOTHER Mary Hall

13. BIRTHPLACE OF MOTHER (State or Country) Floyd Co -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ezekiel T. Sanders
(Address) Pocatello

15. Filed Feb 19 1920 O. A. Sheets
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 18 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1920, to Feb 18 1920, that I last saw him alive on Feb 19 1920 and that death occured on the date stated above, at 9a. M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Ray M. D.
2/21 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Inkom Ida. | DATE OF BURIAL 1920

20. UNDERTAKER Silas Hall | ADDRESS Pocatello Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84 — File No. 3
Primary Registration District No. 26 — Registered No. 3207

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 1817 McKinley St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Louise Selders.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Baby

6. DATE OF BIRTH: Dec. (Month) 19. (Day) 1918 (Year)

7. AGE: 1 Yrs. 1 Mos. 29. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello.

10. NAME OF FATHER: Chas E. Selders

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Harriet Fechtel.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas E. Selders
(Address) 1817 Mc Kinley.

15. Filed Feb 17 1920 O P Steele
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12 1920 to Feb 17 1920 that I last saw her alive on Feb. 16 1920 and that death occurred on the date stated above, at 6:50 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Lyman M. D.
Feb 17 1920 (Address) Pocatello

*State the *Disease Causing Death*; or in deaths from *Violent Causes*, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida — DATE OF BURIAL: Feb 18 1920

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

28754

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. 227 S. 2nd St.)

File No. 31

Registered No. 3215

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary A Powell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: July 9. (Month) (Day) 1833 (Year)

7. AGE: 86 Yrs. 6 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife. Widow.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis E Sanders
(Address) Pocatello Ida

15. Filed Feb 18 1920 O B Steely Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug? 1920, to Feb 16 1920
that I last saw her alive on Feb 16 1920
and that death occurred on the date stated above, at 6 1130 M.

The CAUSE OF DEATH* was as follows: Pneumonia, Influenza.

3 or 4 days. (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Mays M. D.

2/17 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho | DATE OF BURIAL: Feb 19 1920

20. UNDERTAKER: Whitaker | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28755

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. General Hospital St.)

File No. 31
Registered No. 3204
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vada Woolley Ricks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
June 18 1893
(Month) (Day) (Year)

7. AGE
26 yrs. 7 mos. 28 da.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Paris Idaho.

10. NAME OF FATHER H. L. Woolley

11. BIRTHPLACE OF FATHER (State or Country) Paris Idaho

12. MAIDEN NAME OF MOTHER Minerva Rich

13. BIRTHPLACE OF MOTHER (State or Country) Paris Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. A. Ricks
(Address) 545 - No Hayes

15. Filed Feb 17 1920 O. P. Woolley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February 16 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1919 to July 16 1920
that I last saw h[illegible] alive on July 16 1920
and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
July 17 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake City Ut.	Feb 20 1920

20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28756

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 84

County of Bannock Primary Registration District No. 2 [illegible]

City of Pocatello (No. 657 N. Eleventh)

File No. 31

Registered No. 3203

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret R. Manison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH Jan 9th 1886
(Month) (Day) (Year)

7. AGE 34 yrs. 1 mos. 5 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Michael Raidy

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Margaret Barry

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C C Raidy
(Address) 517 N Lander St

15. Filed Feb 16, 1920 O B Leas Registrar
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 14th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1920 to Feb 14 1920
that I last saw her alive on Feb 14 1920
and that death occurred on the date stated above, at 8:20 A. M.

The CAUSE OF DEATH* was as follows:

Filet pneumonia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary) Pregnancy

(Duration) yrs. mos. ds.

(Signed) J. C. W. Lynn M. D.

Feb. 16 1920 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Interment Pocatello | DATE OF BURIAL Feb 16 1920

20. UNDERTAKER Summerhays & Hay | ADDRESS Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

28757

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2 6
File No. 31
Registered No. 32 12

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gene Lucile West

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1920 (Year)

7. AGE: Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: baby
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mackay Idaho

10. NAME OF FATHER: Alvin West

11. BIRTHPLACE OF FATHER (State or Country): Centerville Idaho

12. MAIDEN NAME OF MOTHER: Minnie Fox

13. BIRTHPLACE OF MOTHER (State or Country): Philadelphia Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alvin West
(Address) Mackay Idaho

15. Filed Feb 13 1920 C B Steele Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6th 1920 to Feb 12th 1920 that I last saw her alive on Feb 12th 1920 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) none
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Gwynn M. D.
Feb 12 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I W Walker Cem
DATE OF BURIAL: Feb 13 1920

20. UNDERTAKER
ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Dr Root.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28758

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
File No. 31
Registered No. 3231

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 752 N. Harrison St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Ellen F. Shea

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed
6. DATE OF BIRTH: June 9th 1852 (Month) (Day) (Year)
7. AGE: 68 yrs. 8 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Mass
10. NAME OF FATHER: Morris Sisk
11. BIRTHPLACE OF FATHER (State or Country): Ireland
12. MAIDEN NAME OF MOTHER: Mary Lynch
13. BIRTHPLACE OF MOTHER (State or Country): Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm B. Shea
(Address) 752 N. Harrison
15. Filed Feb 11 1920 O B Lee Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 11th 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1920 to Feb 11 1920
that I last saw her alive on Feb 11 1920
and that death occurred on the date stated above, at 10 M.
The CAUSE OF DEATH* was as follows:
(a) Pneumonia
(Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John J. Root M. D.
2/11 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Cedar Rapids Iowa
DATE OF BURIAL: Feb 16 1920
20. UNDERTAKER: Schumacher & Hall
ADDRESS: City

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

25759

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 6
File No. 3
Registered No. 32

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 1117 S 5th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia L. Wright

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Aug 20th 1918 (Month) (Day) (Year)
7. AGE: 1 yrs. 5 mos. 21 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Bert S. Wright
11. BIRTHPLACE OF FATHER (State or Country): Kansas
12. MAIDEN NAME OF MOTHER: Pearl Elliott
13. BIRTHPLACE OF MOTHER (State or Country): Kansas
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bert S. Wright
(Address) 1117 S. 5th St.
15. Filed Feb 13. 1920 A Keefe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 11 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1920, to Feb 11 1920
that I last saw her alive on Feb 11 1920
and that death occurred on the date stated above, at 7 P.M.
The CAUSE OF DEATH* was as follows:
Meningitis
(Duration) yrs. mos. 6 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 7 ds.
(Signed) O. B. Steers M. D.
2-13, 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Inglewood Cem. DATE OF BURIAL: Feb 13 1920
20. UNDERTAKER: Shoemaker & Kay ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-19.

28760

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 74
Primary Registration District No. 2 61
File No. 3
Registered No. 399

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Pearson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 20 (Day) 1889 (Year)

7. AGE: 30 Yrs. 7 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hoyt Kansas

10. NAME OF FATHER: W T Pyle.

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Pearson
(Address) 604 No Arthur

15. Filed Feb 10, 1920 O P Steele
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1920, to Feb 9 1920, that I last saw h[illegible] alive on Feb 9 1920, and that death occurred on the date stated above, at 5a.M.
The CAUSE OF DEATH* was as follows:
Influenza Pneumonia
(Duration) Yrs. ..... mos. 5 ds.
Contributory (Secondary) Influenza
(Duration) yrs. ..... mos. ..... ds.
(Signed) J M Kay M. D.
2, 1920 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible]
DATE OF BURIAL: 2-10 1920

20. UNDERTAKER: Neil J Walker
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Rec'd.

28761

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cannon

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 87

Primary Registration District No. 276

(No. 242 No 1st Ave St.)

File No. 31

Registered No. 3178

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ruda Collins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: June (Month) 5 (Day) 1894 (Year)

7. AGE: 24 Yrs. 8 Mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Odessa Russia

10. NAME OF FATHER: Jacob Schmierer

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Cristina Loco

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Boyd Clay Collins
(Address) Bartlett Iowa

15. Filed Feb 9 1920 O B Steece Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/2 1920, to 2/7 1920, that I last saw her alive on 2/7 1920, and that death occurred on the date stated above, at 10.10 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) F. W. Lynn M. D.

2/7 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 2/9 1920

20. UNDERTAKER P. I. Nielsen ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. Read instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Steele

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28762

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 5
Registered No. 397

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 218, N. Garfield St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Michael A. Mullin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Sept 10th 1870
(Month) (Day) (Year)

7. AGE: 49 yrs. 4 mos. 27 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R.R. Engineer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Michael Mullin

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Eliza Walsh

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Michael Mullin
(Address) #218 N. Garfield, City

15. Filed Feb 9, 1923 O. F. Steele Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 7th 1923
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1923, to Feb 6, 1923 that I last saw him alive on Feb 6 1923 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Contracted Cancer
Cancerous

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Pocatello Ida M. D.

Feb 9, 1923 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Feb 12 1923

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

28763

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics,

Registration District No. 84

Primary Registration District No. 2

File No. 3

Registered No. 396

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. 1610 McKinley Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry J Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1919 (Year)

7. AGE: Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: J. N. Brown

11. BIRTHPLACE OF FATHER (State or Country): Woodstock Ontario

12. MAIDEN NAME OF MOTHER: Annie Briscoe

13. BIRTHPLACE OF MOTHER (State or Country): Liverpool Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. N. Brown

(Address) 1610 McKinley Ave Pocatello Ida

15. Filed Feb 6 1920 O B Stood Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 5-th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1920, to Feby 5-th 1920

that I last saw him alive on Feby 5 1920

and that death occurred on the date stated above, at 2.35 P. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) very weak baby when born

(Duration) ..... yrs. 4 mos. 26 ds.

(Signed) J. V. Tyson M. D.

2 5 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New cemetery — DATE OF BURIAL: 2 6 1920

20. UNDERTAKER: W. T. Walker — ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

28764

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5
Primary Registration District No. 2 01
(No. 415, South Hayes St.)

File No. 3
Registered No. 3 34
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orson Glenn Buckstead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: February (Month) 1 (Day) 1920 (Year)

7. AGE: — yrs. — mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: Orson Lee Buckstead

11. BIRTHPLACE OF FATHER (State or Country): Spanish Fork Utah

12. MAIDEN NAME OF MOTHER: Amy Josephine Allen

13. BIRTHPLACE OF MOTHER (State or Country): Victory Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Orson L Buckstead
(Address) 415 South Hayes

15. Filed Feb 3 1920 O P Bird Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to 2-2 1920, that I last saw h— alive on Feb 2 1920 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Inanition - Non closure of foramen ovale

(Duration) ... yrs. ... mos. 2 ds.

Contributory (Secondary) ✓

(Duration) ... yrs. ... mos. ... ds.

(Signed) O P Bird M. D.
3-1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem
DATE OF BURIAL: 2-3 1920

20. UNDERTAKER: Schumacher & Hall
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

28765

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. ..... , ... St.)

Registration District No. 24

Primary Registration District No. 210

File No. 3

Registered No. 373

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John W Graham.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE 67 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Salesman.

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Union Town Ky.

10. NAME OF FATHER J W Graham.

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER Varina C Marrow

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Buford B Graham

(Address) 549 - North Hayo.

15. Filed Feb 10, 1920 O B Cook Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1920, to Feb 8 1920, that I last saw h.m. alive on Feb 8 1920, and that death occurred on the date stated above, at 2:35 M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

..... (Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. Newton M. D.

Feb 9 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grace Ida	2-10 1920

20. UNDERTAKER Will J. Walker. ADDRESS Grace Ida

newton.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

28766

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cannock — Registration District No. 84

City of Pocatello — Primary Registration District No. 2 6

(No. 1149 80 Harrison St.)

File No. 3

Registered No. 3 92

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecelia Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 16 (Day) 1906 (Year)

7. AGE: 13 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business or establishment in which employed (or employer): None.

9. BIRTHPLACE (State or Country): Helena Mont

10. NAME OF FATHER: C. H. Dewey

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. B. Edwards

(Address) Pocatello

15. Filed Feb 2 1920 C. B. Seely Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from / 19..., to / 19..., that I last saw h... alive on ..... 19..., and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows: Suicide by taking Carbolic Acid

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. S. Ferguson Coroner M. D.

7/2 1920 (Address) 352 So 8th

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 7/3 1920

20. UNDERTAKER: W. D. Walker — ADDRESS: Pocatello

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28767

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

County of Bannock

Primary Registration District No. 2 64

City of Pocatello (No. 615 - So. Lipsh St.)

File No. 31

Registered No. 3, 91

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosa Linn Gleason

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: December 2 1838
(Month) (Day) (Year)

7. AGE: 81 yrs. 1 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Samuel Cook

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Asenith Cook

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F J Gleason
(Address) 615 - So. Lipsh

15. Filed Jan 31 1920 O R Reese Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January 31 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1920, to Jan 31 1920 that I last saw her alive on Jan 31 1920 and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Senility

(Duration) yrs. mos. 3 ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) J. Wm. H. Deering M. D.
Jan 31 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moline Ill. DATE OF BURIAL: Jan 31 1920

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M:1-16-12

CERTIFICATE OF DEATH

28768

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64

Primary Registration District No. 2101

(No. 408, North 7th St.)

File No. 31

Registered No. 390

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Luginbuhl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 14 (Day) 1842 (Year)

7. AGE: 77 yrs. 9 mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Christian Luginbuhl

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elizabeth Leichti

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A J Garn

(Address) 40 E- No 7th

15. Filed Feb 2 1920 O P Reese Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191 , to 191 , that I last saw h— alive on Jan 21 1920 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Dropsy Cardiac Dilatation

(Duration) — yrs. mos. ds.

Contributory (Secondary) Senility

(Duration) — yrs. mos. ds.

(Signed) O P Reese M. D.

Feb 2 1920 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City — DATE OF BURIAL: Feb 3 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28769

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2 0 9
File No. 21
Registered No. 389

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 231, N. Garfield St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James J. Burns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH Dec 23rd 1861
(Month) (Day) (Year)

7. AGE 58 yrs. 1 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Railroad
(b) General nature of industry business, or establishment in which employed (or employer) Engineer

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER James J. Burns

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James J Burns
(Address) 231 N Garfield

15. Filed Jan 30 1920 E. O. Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Jan 30th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1919, to Jan 30 1920, ~~that I last saw him alive on 191~~, and that death occurred on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows:
Heart embolism.
Probably embolism 2
death almost instantly
(Duration) yrs. mos. ds.
Contributory (Secondary) a fever pneumonia
(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.
Jan 30 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Interment Riverside | DATE OF BURIAL Jan 31 1920

20. UNDERTAKER [illegible] | ADDRESS [illegible] City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

28770

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31
Registered No. 3188
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. 820 N. Harrison St.)

2. FULL NAME Daisy Opal Macdonald

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Single

6. DATE OF BIRTH. October 12, 1919
(Month) (Day) (Year)

7. AGE — Yrs. 3 Mos. 18 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Pocatello Idaho

10. NAME OF FATHER William H. Macdonald

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Daisy Mundleus

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daisy Macdonald
(Address) 820 N. Harrison St.

15. Filed Jan. 30 1920 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 29 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1920 to Jan 29 1920 that I last saw her alive on Jan 28 1920 and that death occurred on the date stated above, at 1. a. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) Few days. Yrs. ..... mos. ..... ds.

Contributory (Secondary) Lagrippe

(Duration) Few days. Yrs. ..... mos. ..... ds.

(Signed) H. L. McKay M. D.
1/31 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mt View Cemetery — DATE OF BURIAL Jan 31 1920

20. UNDERTAKER H. L. McKay — ADDRESS Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

28771

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2564
File No. 3
Registered No. 387

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 618 N. 3rd St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Driskell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1885 (Year)

7. AGE: 35 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Hunt Co Texas

10. NAME OF FATHER: Henry Oxford

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Foster Driskell
(Address) 618 N. 3rd Pocatello Ida

15. Filed Jan 31 1920 O B Steely Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1919, to January 1920, that I last saw her alive on January 1920, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
apoplexy cerebral hemorrhage
Brain
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) ..... Nil
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Lynn M. D.
Jan 29 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenville Texas
DATE OF BURIAL: 2/1/1920

20. UNDERTAKER: W. H. Wallace
ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

28772

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

County of Bannock

Primary Registration District No. 2461

City of Pocatello

(No. 645, South Third St.)

File No. 30

Registered No. 3185

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Lucile Rytting

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 16 (Day) 1907 (Year)

7. AGE: 12 yrs. 5 mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lyman Idaho

10. NAME OF FATHER: Chas F. Rytting

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Emma L. Millward

13. BIRTHPLACE OF MOTHER (State or Country): Grantsville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. C. F. Rytting
(Address) Rytting Idaho

15. Filed Jan 25 1920 O. P. Reese Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 17 1920, to Jan 24 1920, that I last saw her alive on Jan 24 1920 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Influenza Epidemic

(Duration) yrs. mos. 8 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. J. Howard M. D.

Jan 26 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lyman Idaho | DATE OF BURIAL: Jan 26 1920

20. UNDERTAKER: Schumacher & Hall | ADDRESS: Pocatello

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28773

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 12-4
File No. 31
Registered No. 3184

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Sede

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Exact date unknown 1869
(Month) (Day) (Year)

7. AGE: 51 yrs. mos. ds. (Mean as known) IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Supt General Hospital
(Address) Pocatello Idaho

15. Filed Jan 26 1920 O B Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan 24th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920 to Jan 24 1920
that I last saw he alive on Jan 22 1920
and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows: Pneumonia (Broncho)

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W Bruce Boeeuw M. D.
Jan 26 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho | DATE OF BURIAL: Jan 26 1920

20. UNDERTAKER: Chamberlain & Hays | ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

28774

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ..... File No. .....

Primary Registration District No. ..... Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Fort Hall Springs Ida (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roscoe Hopper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. not known (Month) 1 (Day) (Year)

7. AGE: about 30 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cattles
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): not known

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Hansen
(Address) Fort Hall Springs Ida

15. Filed Jan 27 1920 O B Steen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920, to Jan 22 1920, that I last saw h.im alive on Jan 22 1920, and that death occured on the date stated above, at 3 30 PM.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) not known Yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis

(Duration) not known yrs. ..... mos. ..... ds.

(Signed) O T Hemming M. D.

19..... (Address) Fort Hall Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos. 7 days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? not known

Former or usual residence Rupert Ida

19. PLACE OF BURIAL OR REMOVAL: Pocatello — DATE OF BURIAL: Jan 24 1920

20. UNDERTAKER: W E T Walker — ADDRESS: Pocatello, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS YORK CO., PTRS. & SORS. 24654

28776

FORM V. S. No. 1-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 21
(No. [illegible] St.)

File No. 30
Registered No. 381
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hawkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept 16 1864 (Month) (Day) (Year)

7. AGE: 55 Yrs. 4 Mos. 4 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pattuck Mo

10. NAME OF FATHER: John Hawkins

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Malletta Whitworth

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Hawkins
(Address) Pocatello Idaho

15. Filed Jan 20 1920 O. Rees Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany 20 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1920 to Jany 20 1920 that I last saw him alive on Jany 19 1920, and that death occurred on the date stated above, at 3:30 a. M.

The CAUSE OF DEATH* was as follows:
1. Organic Heart disease (Mitral insufficiency)
2.
(Duration) 15 Yrs. mos. ds.
Contributory (Secondary) Chronic interstitial nephritis (Duration) 10 yrs. mos. ds.

(Signed) W. W. Brothers M. D.
Jan 20 1920. (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 17 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Robin Idaho
Former or usual residence Robin Idaho

19. PLACE OF BURIAL OR REMOVAL: Arimo Idaho | DATE OF BURIAL: 1/20 1920

20. UNDERTAKER: H. B. Walker ADDRESS Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

28777

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2 6
File No. 3 2
Registered No. 3 5 1

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 846 N. Grant St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosamond Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. Jan 7 1920 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: John W. Williams

11. BIRTHPLACE OF FATHER (State or Country): Idaho Falls Ida

12. MAIDEN NAME OF MOTHER: Rosamond Greene

13. BIRTHPLACE OF MOTHER (State or Country): Grantsville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Williams
(Address) 846 N. Grant

15. Filed Jan 19 1920 O B Steed
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 19 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1920 to Jan 19 1920
that I last saw her alive on Jan 19 1920
and that death occurred on the date stated above, at 2 a.m.
The CAUSE OF DEATH* was as follows:
Ptomaine (7 mos baby)

(Duration) Yrs. — mos. 12 ds.
Contributory (Secondary): Malnutrition
(Duration) Yrs. — mos. 12 ds.

(Signed) W. J. Howard M. D.
1/19 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State ....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence: Pocatello

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Jan 20 1920

20. UNDERTAKER: H. L. McStan — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28778

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 30
Registered No. 3179

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 1534, Taft Avenue (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Naoma Wheelock
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 25 (Day) 1904 (Year)

7. AGE: 15 yrs. 7 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: J. A. Wheelock

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Cora Christensen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Wheelock
(Address) 1534 Taft Ave.

15. Filed Jan 19 1920 O. K. Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1920 to Jan 16 1920
that I last saw her alive on Jan 16 1920
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) 7 yrs. — mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos. D. Lynn M. D.
Jan 17 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: Jan 20 1920

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

28779

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30
Registered No. 3178
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 84
Primary Registration District No. 2
(No. General Hosp St.)

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Ernst

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. June (Month) 27 (Day) 1891 (Year)

7. AGE: 27 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Custer Idaho

10. NAME OF FATHER: George A. Ernst

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER: Susie Williams

13. BIRTHPLACE OF MOTHER
(State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susie Ernst
(Address) 912 N. 9th ave Pocatello

15. Filed Jan. 19. 1920. T. R. Keely
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11 1919 to Jan. 17 1920
that I last saw him alive on Jan. 17 1920
and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Charles H. Gregory M. D.
1-19 1920 (Address) Rural Boy

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 1 mos. ....days. In the State Life ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence Pocatello Ida

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem
DATE OF BURIAL: Jan. 20 1920

20. UNDERTAKER: H. L. McClain
ADDRESS: Pocatello Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28780

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

County of Bannock

Primary Registration District No. 2 61

File No. 31

City or Pocatello (No.) St. Anthony Hospital (St.)

Registered No. 3219

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johanna Caroline Riebandt

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: March 25th 1825
(Month) (Day) (Year)

7. AGE: 94 yrs. 10 mos. 20 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: August Gutzkner

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Eischstedt

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John A. Riebandt
(Address) 554 W Bonneville

15. Filed Feb 16, 1920 O P Keen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 15th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1920 to Feb 15, 1920
that I last saw h[illegible] alive on Feb 15, 1920
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) 1 yrs. mos. ds.
Contributory (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) O P Keen M. D.
2-16, 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Idaho | DATE OF BURIAL: Feb 19 1920

20. UNDERTAKER: Schumacher & Hall | ADDRESS: City

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

25781

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31

Registered No. 32 15

1. PLACE OF DEATH

County of Bannock Registration District No. 24

City of McCammon (No. Residence St.) Primary Registration District No. 2 61

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Burley Shumway

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: December 5 1899 (Month) (Day) (Year)

7. AGE: 20 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Franklin Idaho

10. NAME OF FATHER: James Henry Shumway

11. BIRTHPLACE OF FATHER (State or Country): Mendon Utah

12. MAIDEN NAME OF MOTHER: Edith Kirby

13. BIRTHPLACE OF MOTHER (State or Country): Hyde Park Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J. H. Shumway

(Address) McCammon

15. Filed Mch 1 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1920, to Feb 27 1920 that I last saw him alive on Feb 27 1920 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Fracture of the skull at the base.

(Duration) ..... Yrs. ..... mos. 12 hrs

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wilson J McDill M. D.

Mch 1 1920 (Address) McCammon Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Franklin Idaho — DATE OF BURIAL: Mch 2 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28782
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Lund
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

2. FULL NAME Sophus R. Hansen.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single. (Write the word.)

6. DATE OF BIRTH: May 27 1918 (Month) (Day) (Year)

7. AGE: 1 Yrs. 9 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lund Idaho

10. NAME OF FATHER: Ernestus S. Hansen.

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah

12. MAIDEN NAME OF MOTHER: Mary S. Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Brigham Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Peters B Jensen
(Address): Lund Idaho.

15. Filed FEB 20 1920 19
O. W. Lundt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 4 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26 1920 to Feb March 4 1920 that I last saw him alive on March 4 1920, and that death occurred on the date stated above, at 12.45 P. M.

The CAUSE OF DEATH* was as follows:

Acute Mouth Lobar Pneumonia.
Both lungs lobar -

(Duration) Yrs. mos. 11 ds.
Contributory (Secondary): Myocarditis

(Duration) Yrs. mos. 2 ds.

(Signed) Orem O. Lundt M. D.
3/4 1920 (Address) Bancroft Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lund Idaho. DATE OF BURIAL: 3/6 1920.

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28783

Registered No.

1. PLACE OF DEATH

County of Bannock

City of Hatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gerald LeRoy Christensen,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: February 3rd, 1920 (Month) (Day) (Year)

7. AGE: Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hatch Idaho.

10. NAME OF FATHER: Alex McGee Christensen

11. BIRTHPLACE OF FATHER (State or Country): Thatcher Idaho.

12. MAIDEN NAME OF MOTHER: R.Diana Hogan

13. BIRTHPLACE OF MOTHER (State or Country): Hatch Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex McGee Christensen per O.V.L.
(Address) Hatch Idaho.

15. Filed FEB 10 19..

O. V. Linstead
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 3rd, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb.3rd 1920 to Feb.3rd, 1920 that I last saw him alive on Feb.3rd, 1920, and that death occurred on the date stated above, at 2.40 P.M.

The CAUSE OF DEATH* was as follows:
congenital atelectasis.

(Duration) Yrs. mos. 4 hours. ds.

Contributory (Secondary) premature birth.

(Duration) yrs. 4 hours. mos. ds.

(Signed) O. V. Linstead M. D.

Feb.12 1920 (Address) Bancroft Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chesterfield Ida. DATE OF BURIAL: Feb.5 1920

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE, IDA. 1088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

28784

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 33
Primary Registration District No. 2132
File No. 103
Registered No. .....

1. PLACE OF DEATH
County of Bear Lake
City of Paris
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stanley Shepherd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, ~~MARRIED~~, WIDOWED OR ~~DIVORCED~~. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1916 (Year)

7. AGE 3 Yrs. 2 Mo. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Edw. Tracy Shepherd

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Eliza Roberts

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edwin T. Shepherd
(Address) Paris Idaho

15. Filed 2/10 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febr (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1920 to Jan 31 1920, that I last saw h.. alive on Jan 31 1920 and that death occured on the date stated above, at 1.20 A.M.

The CAUSE OF DEATH* was as follows:
Suppression of urine with Albuminic Intoxication as secondary

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Chr. Bronchitis
(Duration 3 yrs. ..... mos. ..... ds.

(Signed) C. O. Moore M. D.
Feb 3 1920 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Paris Ida. DATE OF BURIAL 2/4/20

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STATE - YORK CO., PTRS. & BKBS. 24858

FORM V. S. No. 3-25 M. 1-16-13

28785

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bear Lake — Registration District No. 33

City of Paris — Primary Registration District No. 2132 — (No. ..... St.)

File No. 102

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Bolton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 14 (Day) 1848 (Year)

7. AGE: 71 Yrs. 3 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Smith

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Ann Mole

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D L Bolton
(Address) .....

15. Filed 2/10/20 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920 to Feb 21 1920, that I last saw her alive on Feb 21 1920 and that death occured on the date stated above, at 6 40 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia, L Lb + R. Lb

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. O. J. Moore M. D.
2-22 1920 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & STRS. 24658

28786

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 33
Primary Registration District No. 2132
(No. ....., ... St.)

File No. 104
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. John T. Parsey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Dec. (Month) 3 (Day) 1864 (Year)

7. AGE: 55 yrs. 3 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Geoge Neat

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Fowler

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John T. Parsey
(Address) Paris, Idaho.

15.
Filed 3/10 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-25 1920 to 3-3 1920 that I last saw h[illegible] alive on 3 3 1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Cancer Liver
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Age
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lamark
DATE OF BURIAL: 3-6 1920

20. UNDERTAKER: Bishop Low
ADDRESS: Paris, Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 28787

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bear Lake

City of Montpelier

Registration District No. 52

Primary Registration District No. 2136

(No. ....., ... St.)

File No. .....

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jens C Esterholt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. March (Month) 30 (Day) 1845 (Year)

7. AGE: 74 Yrs. 9 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Peter Esterholt. (?)

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER: (?) Larson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jens C Esterholt
(Address) Pegram.

15. Filed 1-9 1920

Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-5 1920, to 1-8 1920 that I last saw h... alive on 1-8 1920 and that death occured on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hem

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration 4 yrs. mos. ds.

(Signed) Jens C Esterholt M. D.

1-9 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dingle Idaho — DATE OF BURIAL: Jan 10 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5-2
Primary Registration District No. 2136
(No. ..... St.)

File No. 28188
Registered No. .....

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane McCammon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: March (Month) 18 (Day) 1841 (Year)

7. AGE: 78 Yrs. 11 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER John Hauseworth

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Gaskins
(Address) Montpelier, Idaho

15. Filed 3-1- 1920 — W. W. Thomas, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1920, to Jan 12 1920, that I last saw h.. alive on Jan 12 1920, and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Exhaustion, due to
Trigeminal Neuralgia
(Duration) 20 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. P. Gaylord M. D.
1-12 1920 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Georgetown Idaho
DATE OF BURIAL: Jan 16 1920

20. UNDERTAKER: H. W. Williams
ADDRESS: Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. [illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52

Primary Registration District No. 2136

File No. 2876

1. PLACE OF DEATH
County of Bear Lake
City or Town of Montpelier (No. ..... St.)

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurs a day or more after entry, fill in and report at once. If not, give information as directed under special information.

2. FULL NAME Sarah Hebdon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 3 (Day) 1875 (Year)

7. AGE: 44 Yrs. 7 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: Able Smart.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Sarah Gittens

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cattie M Dyls
(Address) Georgetown Ida

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920, to Jan 25 1920, that I last saw h. Er. alive on Jan 22 1920, and that death occured on the date stated above, at [illegible] A. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. [illegible] da.

Contributory (Secondary) Heart trouble

(Duration) ..... yrs. ..... mos. [illegible] da.

(Signed) Elmer E. Hinckley

1-25 1920 (Address) Montpelier, Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs. .....
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE O[illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PENCIL should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Example of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
(No. ..... St.)

File No. 28790
Registered No. .....

1. PLACE OF DEATH:
County of Bear Lake
City of Georgetown
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph LeRay Wixom

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 9 (Day) 1883 (Year)

7. AGE: 37 Yrs. ..... Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph M Wixom

11. BIRTHPLACE OF FATHER (State or Country): Utah ?

12. MAIDEN NAME OF MOTHER: Elvira Picks

13. BIRTHPLACE OF MOTHER (State or Country): Utah ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Ray Wixom
(Address) Georgetown

15. Filed 3-1-1920 A. Perkins Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1920, to Jan 28 1920, that I last saw him alive on Jan 28 1920, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Influenza
.....
.....
.....(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Elmer E. Hinckley M. D.
Jan 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Georgetown — DATE OF BURIAL: Jan 28 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 28791
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emily S. Hoff

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 8 (Day) 1893 (Year)

7. AGE: 26 Yrs. 4 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chris Sorensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Alice Leffetts

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ernest P. Hoff
(Address) Georgetown

15. Filed 3-1-20
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to Jan 28 1920, that I last saw h[illegible] alive on Jan 28 1920, and that death occured on the date stated above, at 11:12 P.M.
The CAUSE OF DEATH* was as follows: "Flu"

..... (Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Pneumonia
..... (Duration) ..... yrs. ..... mos. 13 ds.
(Signed) Elmer E. Hinckley M. D.
2/2, 1920. (Address) Montpelier, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Georgetown
DATE OF BURIAL: Jan 29 1920

20. UNDERTAKER: F. M. Williams
ADDRESS: Montpelier Ida

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 28792
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isabelle F. Moore
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: 2 (Month) 2 (Day) 86 (Year)

7. AGE: 34 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: W. B. Furgeson.

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Stevenson

13. BIRTHPLACE OF MOTHER (State or Country): USA.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Moore
(Address) Montpelier

15. Filed 2-1-1920
H. H. Keeney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 29th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920 to Jan 29 1920, that I last saw h[illegible] alive on Jan 29 1920, and that death occurred on the date stated above, at 4 45a M.

The CAUSE OF DEATH* was as follows:

Influenza.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. F. Albee M. D.

2-3-1920 (Address) Montpelier Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Terre Haute, Indiana — DATE OF BURIAL: Feb 7 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28793

Registered No. .....

Registration District No. 52

Primary Registration District No. 2136

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier

2. FULL NAME John Roberts Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct (Month) 26 (Day) 1881 (Year)

7. AGE: 38 Yrs. 3 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Car Inspector
(b) General nature of industry, business, or establishment in which employed (or employer): A & L R R.

9. BIRTHPLACE (State or Country): Pittsburgh Allegheny Co Penn

10. NAME OF FATHER: Jacob Williams

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Lizzie Roberts

13. BIRTHPLACE OF MOTHER (State or Country): Wheeling West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David W Davis
(Address) Montpelier Idaho

15. Filed 3-9- 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1920 to Feb 2 1920 that I last saw h... alive on Feb 2 1920 and that death occured on the date stated above, at 7a M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
(Duration) - yrs. - mos. - ds.
(Signed) Earl E Cobbley M. D.
2-20 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Feb. 5 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & ENGS. 24958

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28794

Registered No. .....

1. PLACE OF DEATH

County of Bear Lake

City of Georgetown

Registration District No. 52

Primary Registration District No. 2136

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilson Blaine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan. (Month) 27 (Day) 1858 (Year)

7. AGE: 61 Yrs. 10 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): (Retired 7 yrs)

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Wilson Blaine

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Lucinda Wintenstein

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. J. Blaine

(Address) Georgetown Idaho

15. Filed 3-9-1920

H. H. Kemp
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h.. alive on Feb 1, 1920,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Paralysis

Was called in to Catheterize Mr. Blaine but made no diagnosis or prescribed no treatment & Patient under care of Dr. G. F. Ashley

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G. P. Gaertner M. D.

(Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Feb. 5 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bear Lake
City of Montpelier

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 28795
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sylvia A Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Dec (Month) 22 (Day) 1888 (Year)

7. AGE: 31 Yrs. 2 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John S Jewett.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Mary Susannah Gibbs

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John D. Jarrett
(Address) Montpelier Idaho

15. Filed 3-9- 1920
H. H. Kerr
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 5th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-1 1920, to 2-4 1920
that I last saw h[illegible] alive on 2-4 1920
and that death occured on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Angina Pectoris

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. E. Cosby M. D.
2-6 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho
DATE OF BURIAL: Feb 5 1920

20. UNDERTAKER: J. M. Williams
ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 82
Primary Registration District No. 2136
File No. 28296
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Daniel Schmid

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 15 (Day) 1898 (Year)

7. AGE: 22 Yrs. Mos. 19 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Tailoress
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charles Schmid

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elva Von Allmen

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Schmid
(Address) Montpelier, Idaho

15. Filed 3-4-20 H. H. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1920, to Feb 3 1920, that I last saw h[illegible] alive on Feb 3 1920, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. 5 ds.
Contributory (Secondary) Broncho Pneumonia
(Duration) yrs. mos. 4 ds.

(Signed) C. P. Gaertner M. D.
2/4 1920 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida. DATE OF BURIAL: Feb 6 1920

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (*b*) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 52

Primary Registration District No. 2136

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28797

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl A. Birch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October 15th 1910 (Month) (Day) (Year)

7. AGE: 9 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Bear Lake Co. Ida.

10. NAME OF FATHER Milford Williams Birch

11. BIRTHPLACE OF FATHER (State or Country) Bear Lake Co. Ida.

12. MAIDEN NAME OF MOTHER Pearl Williams

13. BIRTHPLACE OF MOTHER (State or Country) Bear Lake Co. Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mr Milford Birch

(Address) Montpelier Ida.

15. Filed 3-9-1920

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo. E. Cuthbert M. D.

2-6 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Feb 6 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF ~~DEATH~~.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62

Primary Registration District No. 2136

File No. 28798

(No. ....., ... St.)

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah E. Lewis Sparks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Nov. 1883.
~~Feb 3d~~ (Month) ~~3d~~ (Day) ~~1920.~~ (Year)

7. AGE: 37 Yrs. 3 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Paris, Ida.

10. NAME OF FATHER: Joseph Lewis

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary A. Male

13. BIRTHPLACE OF MOTHER (State or Country): Lehi, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. Cyril Sparks
(Address) Montpelier

15. Filed 3-9-1920. H. H. King Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 3rd. 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 26 1920, to Feb 3rd 1920, that I last saw h alive on Feb 3rd 1920 and that death occured on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Elmer C. Hinckley M. D.

Feb 3 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Feb 6 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6-2
Primary Registration District No. 2136
File No. 28799
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frederick Peter Schuyler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Dec (Month) 7 (Day) 1897 (Year)

7. AGE
22 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): -

9. BIRTHPLACE
(State or Country) Montpelier Ida

10. NAME OF FATHER
John D Schuyler

11. BIRTHPLACE OF FATHER
(State or Country) Salt Lake City Utah

12. MAIDEN NAME OF MOTHER
Mary Ann Pierce

13. BIRTHPLACE OF MOTHER
(State or Country) Long Island New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John D Schuyler.
(Address) Montpelier Ida.

15.
Filed 3-9 1920
H H Reiny
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 (Month) V (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-1 1920, to 2-V 1920
that I last saw h... alive on 2 V 1920
and that death occured on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Geo. E. Cubley M. D.
2-1 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Mch 8 1920

20. UNDERTAKER: F. M. McClenny — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28800

Registered No. .....

Registration District No. 52

Primary Registration District No. 2136

1. PLACE OF DEATH.

County of Bear Lake

City of Montpelier

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Anderson Graff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. June (Month) 23 (Day) 1915 (Year)

7. AGE: 4 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Gustav A. Graff

11. BIRTHPLACE OF FATHER (State or Country) Scranton Penna.

12. MAIDEN NAME OF MOTHER Lydia M. Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gustave Graff

(Address) Montpelier Idaho

15. Filed 3-9-20 1920

N. H. Berry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 5th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1919, to Feb. 5th 1920, that I last saw h... alive on Feb 4th 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza and Pneumonia

(Duration) — Yrs. — mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. H. Berry M. D.

2-5-1920 (Address) Montpelier, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Feb. 7 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 28801
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Soren J Hedley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 14 (Day) 1887 (Year)

7. AGE: 33 Yrs. ..... Mos. 25 ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Polk Co Mo

10. NAME OF FATHER Melville P Headlee

11. BIRTHPLACE OF FATHER (State or Country) Arkansas

12. MAIDEN NAME OF MOTHER Mariah E Kerr

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Melville P Headlee
(Address) Montpelier

15. Filed 3-9-20 1920 — H H Berg, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-2 1920 to 2-7 1920 that I last saw h... alive on 2-7 1920 and that death occured on the date stated above, at 10 15 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jas Corkley M. D.

2-8 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: J M. Williams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 28802
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm H. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Apr (Month) 24 (Day) 1882 (Year)

7. AGE: 37 Yrs. 9 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): R&L Road (OSE)

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: Alfred W Smith

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Ellen Reese

13. BIRTHPLACE OF MOTHER (State or Country): Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alfred W Smith
(Address) Montpelier Idaho

15. Filed 3-1-20 — H H King, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 16th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1920, to Feb 16 1920, that I last saw h alive on Feb 15 1920, and that death occured on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:
Influenzal Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Oakley and Kemp M. D.
2-18 1920 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier, Idaho — DATE OF BURIAL: Feb 19 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 52

Primary Registration District No. 2-36

File No. 28803

County of Bear Lake

City of Montpelier (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Linder

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
female	white	Single

6. DATE OF BIRTH: February 20 (Month) (Day) 1917 (Year)

7. AGE: 1 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Montpelier Idaho

10. NAME OF FATHER Albert J. Linder

11. BIRTHPLACE OF FATHER (State or Country) Montpelier Idaho

12. MAIDEN NAME OF MOTHER Ora Sanders

13. BIRTHPLACE OF MOTHER (State or Country) Bear Lake County Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert J. Linder
(Address) Montpelier Idaho

15. Filed 3-1- 1920 W. W. Rigg Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-15 1920 to 2-20 1920 that I last saw h.e.r alive on 2-20 1920 and that death occurred on the date stated above, at 8 9 M.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) 8 yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. Cudley M. D.

2-26 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida. DATE OF BURIAL: Feb 21 1920

20. UNDERTAKER Rigg. ADDRESS Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 52
County of Bear Lake Primary Registration District No. 2136
City of Montpelier (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Basil Jones

File No. 28804
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Infant

6. DATE OF BIRTH Feb 23rd 1920
(Month) (Day) (Year)

7. AGE ..... yrs. ..... mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Montpelier Idaho

10. NAME OF FATHER Basil Jones.

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Marie Deaton.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Basil Jones.
(Address) Montpelier Idaho

15. Filed 2-29 1920. H. W. Thomas
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH 2 28 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-24 1920 to 2-28 1920 that I last saw h... alive on 2-28 — 1920 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows: Pneumonia
Convulsions

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Grant Cooley M. D.
2-29 1920 (Address) Bennington

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelier Idaho	2-29 1920

20. UNDERTAKER	ADDRESS
J. M. Williams	Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28805
Registered No. 8

1. PLACE OF DEATH.
County of Benewah
City of St Maries
(No. ....., ... St.)
Registration District No. 32
Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Peverly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. (Month) (Day) 1879 (Year)

7. AGE: 41 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E E Conger
(Address) Spokane wash

15.
Filed Feb 27 1920
H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920, to Feb 25 1920, that I last saw him alive on Feb 25 1920, and that death occured on the date stated above, at 4:30 P. M.
The CAUSE OF DEATH* was as follows:
Alimentary intoxication
(Duration) 2 Yrs. mos. 3 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 10 ds.
(Signed) H E Conwall M. D.
2/27 1920 (Address) St. Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane — DATE OF BURIAL: 2/27 1920

20. UNDERTAKER: H E Hunt Co — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S.-No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 28806
Registered No. 7

1. PLACE OF DEATH.
County of Benewah
City of St. Maries
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlotte D. Kendall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. May (Month) 22 (Day) 1915 (Year)

7. AGE: 4 Yrs. 8 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... X
(b) General nature of industry, business, or establishment in which employed (or employer)..... X

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Samuel Kendall

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Edith Lounsbury

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Samuel Kendall
(Address) St. Maries Ida.

15. Filed Feb. 16 1920 H E Hunt Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24953

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 10th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1919, to Feb. 10 1920, that I last saw her alive on Feb. 9th 1920 and that death occured on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH* was as follows:
Hypertrophic Cirrosis of the Liver,
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Congestion + Edema of Lungs
(Duration) 1 yrs. ..... mos. ..... ds.
(Signed) D. Kinnebrew M. D.
3/14 1920 (Address) St. Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn
DATE OF BURIAL: 2-16 1920

20. UNDERTAKER: Mitchell & Meagu
ADDRESS: St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 28807
Registered No. 6

1. PLACE OF DEATH.
County of Benewah
City of St Maries
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amanda E O'Brien

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May (Month) 25 (Day) 1859 (Year)

7. AGE: 20 Yrs. 5 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: Linas Edwards

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Woods

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John F. Young
(Address) Spokane Wash

15.
Filed Feb 11 1920
H E Smith
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5th 1920, to Feb 8th 1920, that I last saw her alive on Feb 5th 1920, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Paralysis of Stomach and bowels with goo pressure affecting heart
(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)
(Duration yrs. 0 mos. ds.

(Signed) Chas D Platt M. D.
2/10 1920 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: O'Brien Ranch — DATE OF BURIAL: 2-11 1920

20. UNDERTAKER: Mitchell & Menager — ADDRESS: St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2049
(No. ..... , ... St.)

File No. 28808
Registered No. 5

1. PLACE OF DEATH.

County of Benewah
City of St Maries

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Z Shramek

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 10 (Day) 1865 (Year)

7. AGE: 70 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Saw File
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: John Shramek

11. BIRTHPLACE OF FATHER (State or Country): Bohemia

12. MAIDEN NAME OF MOTHER: Anna Rolf

13. BIRTHPLACE OF MOTHER (State or Country): Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs. Victoria LeBel
(Address): Gibbs, Idaho

15. Filed Feb 7 1920 — H C Hunter, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24652

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30, 1920, to Feb 7 1920, that I last saw him alive on Feb 7 1920, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary): Influenza

(Duration ..... yrs. ..... mos. 8 ds.

(Signed) C B Smith M. D.

2/7 1920 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? St Maries

Former or usual residence: Coeur D Alene Ida.

19. PLACE OF BURIAL OR REMOVAL: Coeur d Alene — DATE OF BURIAL: 2/8 1920

20. UNDERTAKER: Mitchell & Meagher — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 28809
Registered No. 64

1. PLACE OF DEATH

County of Bonneville
City of Iona
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Criss Henry Carstens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov. (Month) 19 (Day) 1919 (Year)

7. AGE: Yrs. 2 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Almira Wash.

10. NAME OF FATHER Wm B Carstens

11. BIRTHPLACE OF FATHER (State or Country) Wash.

12. MAIDEN NAME OF MOTHER Evelen Henning

13. BIRTHPLACE OF MOTHER (State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B Carstens
(Address) Inwood Idaho

15. Filed Feb. 9 1920 H E Holmes
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Probably Pneumonia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H E Holmes M. D.
2/5 1920 (Address) Bonneville Co., Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wash.	2/5 1920
20. UNDERTAKER	**ADDRESS**
C L Schuland	Tekoa Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28810
Registered No. 4
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Benewah
City of Fassell Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

2. FULL NAME Doris Amy Scott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. January (Month) 4 (Day) 1910 (Year)

7. AGE: 10 Yrs. 1 Mos. 1 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank E. Scott

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Bessie Lyle

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank E. Scott
(Address) Fassell Ida.

15. Filed Feb. 5 1920. H E Hunt Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw her alive on 1920
and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
I did not see this child at all but from what I could ascertain was the cause of death Broncho Pneumonia
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary): Influenza
(Duration) ..... Yrs. ..... mos. 5 ds.
(Signed) Chas D Platt M. D.
Feb 6. 1920 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Maries — DATE OF BURIAL: 2/6 1920

20. UNDERTAKER: H E Hunt Co. — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2172
(No. ..... , ... St.)

File No. 28811
Registered No. 2

1. PLACE OF DEATH.
County of Benewah
City of Plummer.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Pedrick Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. March (Month) 28 (Day) 1844 (Year)

7. AGE: 75 Yrs. 10 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Samuel Thomas.

11. BIRTHPLACE OF FATHER (State or Country): Somewhere Atlantic States Pennsylvania or near

12. MAIDEN NAME OF MOTHER: (maiden name not known) Pedrick

13. BIRTHPLACE OF MOTHER (State or Country): Atlantic states. North,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. Pedrick.
(Address) Plummer, Idaho

15. Filed Mch 8 1920 — H. Jaeger, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from no physician in attendance 191..., to ..... 191....., that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 5 Yrs. — mos. — ds.

Contributory (Secondary)
Asthenia (Duration 5 yrs. — mos. — ds.

(Signed) J. W. Didier M. D.
Mch 8 1920 (Address) Plummer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? East some place
Former or usual residence Corning Iowa

19. PLACE OF BURIAL OR REMOVAL: Plummer. Idaho — DATE OF BURIAL: 3 8 1920

20. UNDERTAKER: H. Jaeger — ADDRESS: Plummer. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2123
File No. 28812
Registered No. 3

1. PLACE OF DEATH.
County of Benwah
City of Plummer, Idaho (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Francis Wyatt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1906 (Year)

7. AGE 13 Yrs. 11 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Webster Co So Dak

10. NAME OF FATHER P A Wyatt

11. BIRTHPLACE OF FATHER (State or Country) Floyd Co. Iowa.

12. MAIDEN NAME OF MOTHER Stella G Monserud.

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P. A. Wyatt
(Address) Plummer Ida.

15. Filed Feb 20 1920 W. E. Jaques Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 10th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4th 1920, to Feb. 10th 1920, that I last saw him alive on Feb 10th 1920, and that death occured on the date stated above, at 1:00P M.

The CAUSE OF DEATH* was as follows:
Spanish-Influenza
Lobar Pneumonia.
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Spanish Influenza
(Duration ..... yrs. ..... mos. 6 ds.

(Signed) ..... M. D.
2/20 1920 (Address) Plummer, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Plummer, Idaho	Feb. 12 1920
20. UNDERTAKER W. E. Jaques.	ADDRESS Plummer Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 28813
Registered No. 8

1. PLACE OF DEATH

County of Bingham
City of Blackfoot (If outside limits of city or village, give township) RFD 3 (No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Peter Jorgensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~ (Write the word.)

6. DATE OF BIRTH: March (Month) 10 (Day) 1885 (Year)

7. AGE: 34 Yrs. 3? Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Niels P Jorgensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Hanna Marie Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J P Jensen
(Address) Shelley Idaho

15. Filed 2-2 1920 Wm Hulse 2-1 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Feb 1st 1920
that I last saw h alive on Feb 1st 1920
and that death occurred on the date stated above, at 7:30 a M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. W Zuck M. D.
2/1 1920 (Address) Firth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Basalt Idaho | DATE OF BURIAL: Feb 3 1920

20. UNDERTAKER: James Dy acting | ADDRESS: Undertaker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1117
File No. 28815
Registered No. 10

1. PLACE OF DEATH

County of Bingham
City of Blackfoot, (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vestal Carl Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 10 (Day) 1894 (Year)

7. AGE: 25 Yrs. 8 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Foreman
(b) General nature of industry, business or establishment in which employed (or employer): Caribou Livestock Co.,

9. BIRTHPLACE: Wilkesborough (State or Country) North Carolina

10. NAME OF FATHER: Johson B. Hall

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Hellen V. Rose

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rosella Mae Hall
(Address) Blackfoot.

15. Filed Feb 4 1920 Mrs Nellie E. Pabst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1920, to Feb 3 1920, that I last saw him alive on Feb 3 1920 and that death occurred on the date stated above, at 8:22 A. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) Yrs. 1 mos. 5 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Beck M. D.
2/4 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mo roland Cemetery — DATE OF BURIAL: 2-8 1920

20. UNDERTAKER: Ed L. Egli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. ____
(No. ____, ____ St.)

File No. 2816
Registered No. 11

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet B. Watson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fmal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 15 (Day) 1879 (Year)

7. AGE: 43 Yrs. 1 Mos. 20 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Garage Man
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Richard M Watson

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Katharen

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lydia Watson
(Address) Blackfoot Ida

15. Filed Feb 7 1920 Mollie E Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to Feb 4 1920 that I last saw h[illegible] alive on Feb 4 1920 and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:
Pneumonia
____ (Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Influenza
____ (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H J Simpson M. D.
2/6 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Gem City Cemetery | DATE OF BURIAL: 2-6 1920

20. UNDERTAKER: E F Reed | ADDRESS: Blackfoot

BYNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28817

Registered No. 12

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. ..... St.)

Registration District No. 121

Primary Registration District No. 2194

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick Murphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 15 (Day) 1839 (Year)

7. AGE: 80 Yrs. 6 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: John Murphy

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary O'Donnell

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Murphy
(Address) Blackfoot Ida R.F.D. 2

15. Filed Feb 7 1920 Mrs. N. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to Feb 5 1920, that I last saw h[illegible] alive on Feb 1 1920, and that death occured on the date stated above, at 5PM.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Fatty degeneration Heart & Chronic rheumatism

(Duration 20 yrs.) ..... mos. ..... ds.

(Signed) M. E. Patrick M. D.

2/6 1920 (Address) Blackfoot Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferncliff Cemetery — DATE OF BURIAL: Feb 8 1920

20. UNDERTAKER: E. F. Peck — ADDRESS: Blackfoot Idaho

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28816

Registered No. 13

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

(No. ..... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christena Lofquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Married

6. DATE OF BIRTH

November 13th 1866
(Month) (Day) (Year)

7. AGE

53 Yrs. 2 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Mr. Spangberg

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Chorate

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs M Quase

(Address) 16 South Cleveland Blackfoot Ida.

15. Filed ..... 19 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February 6th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3rd 1920, to Feb 6th 1920 that I last saw her alive on Feb 6th 1920, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows: Intestinal Obstruction

..... (Duration) not Yrs. known ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J O Hamilton M. D.

2/7 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Firth Ida

19. PLACE OF BURIAL OR REMOVAL Firth Idaho

DATE OF BURIAL Feb 8 1920

20. UNDERTAKER E J Peck.

ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of cert.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28819

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melissa Ann Higby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widow

6. DATE OF BIRTH. April (Month) 19th (Day) 1847 (Year)

7. AGE 73 Yrs. 10 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) Do not know

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) Do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Donovan L. La Reese - Supvr. as per records of Idaho Insane Asylum

(Address) Box 338 Blackfoot, Ida

15. Filed Feb. 10 1920 Mo. [illegible] Date

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 12th 1919, to February 9th 1920, that I last saw her alive on February 9 1920, and that death occured on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion Due to general inanition. Arterial Sclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterial Sclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

2/11 1920 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. 6 mos. 23 days. In the State 27 yrs. 6 mos. 23 days

Where was disease contracted if not at place of death?.....

Former or usual residence Teton, Idaho Fremont county.

19. PLACE OF BURIAL OR REMOVAL Hanthorn Idaho — **DATE OF BURIAL** 2-12 1920

20. UNDERTAKER E J Funk — **ADDRESS** Blackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

File No. 28820
Registered No. 13

1. PLACE OF DEATH

County of Bingham
City of Firth Ida

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mona May Handwerk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Single

6. DATE OF BIRTH: July (Month) 30th (Day) 1913 (Year)

7. AGE: Yrs. 6 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shelley Bingham Co Idaho

10. NAME OF FATHER: Leo Handwerk

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Gertrude Drake

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) Shelley Ida Route 2

15. Filed Feb 10 1920 Mrs Hattie E. Patrick
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Investigated death on Feb 10 1920
19..., to Feb 10 1920,
that ~~I last saw h.~~ alive on ..... 19...,
and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Influenza & Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. W. Zurich M. D.
2-10. 1920 (Address) Firth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelley City Cemetery	Feb 11 1920

20. UNDERTAKER [illegible] ADDRESS Shelley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

(No. Idaho Insane Asylum St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28821

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Rhoda Sharp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. July (Month) 13th (Day) 1854 (Year)

7. AGE: 65 Yrs. 6 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Nat. any.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Marion County, Oregon

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Donovan K. La'Reece, Supt. as per records of Idaho Insane Asylum

(Address) Box 338 - Blackfoot, Ida.

15. Filed Feb 12 1920 Mrs. Nate E. Pate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 11th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept - 6th 1919, to February 11th 1920 that I last saw her alive on Feb - 11th 1920, and that death occured on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Cysto Infection Senile Gangrene. Arterial Sclerosis

(Duration) Yrs. mos. ds.

Contributory (Secondary): Arterial Sclerosis

(Duration) Yrs. mos. ds.

(Signed) E. V. Thayer M. D.

2/11 1920 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 5 mos. 7 days. In the State 1 yrs. 5 mos. 7 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida Cemetery

DATE OF BURIAL: 2/13 191

20. UNDERTAKER: E. J. Peck

ADDRESS: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28822

Registered No. 19

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

(No. 238 No Hunt St.)

Registration District No. 121

Primary Registration District No. 1007

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Martindale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 28 1892 (Month) (Day) (Year)

7. AGE: 27 Yrs. 6 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John A. Martindale

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth J Wright

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) (Mrs.) Isabell Robinson

(Address) Burley Idaho Rt 3

15. Filed Feb 12 1920 Walter E. Patrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920 to Feb 12 1920 that I last saw h[illegible] alive on Feb 12 1920 and that death occurred on the date stated above, at 7:35 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) W. E. Patrie M. D.

Feb 19 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferry City Cemetery | DATE OF BURIAL: Feb 14 1920

20. UNDERTAKER: E J Peck | ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28823

Registered No. 17

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot (No. ..... Maveland St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 19 (Day) 1901 (Year)

7. AGE: 14 Yrs. 4 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Carl Martin

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Anna Kuihn

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carl Martins

(Address) Blackfoot Idaho R 7 B 4

15. Filed Feb 13 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920 to Feb 13 1920, that I last saw h[illegible] alive on Feb 13 1920, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.

2/13 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas Ida — DATE OF BURIAL: Feb 12 1920

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 1067

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28824

Registered No. 14

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

(No. North Cemetery St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Genevieve Dahlstrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 3 (Day) 1919 (Year)

7. AGE: Yrs. 6 Mos. 8 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls, Idaho

10. NAME OF FATHER: Arthur E. Dahlstrom

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Aline Carson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur E. Dahlstrom

(Address) Blackfoot.

15. Filed Feb. 14 1920 Mrs Nales E. Parker
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6th 1920, to Feb 13 1920 that I last saw h-er alive on Feb 13 1920, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) .....Yrs.....mos. 7 ds.

Contributory (Secondary)

(Duration) .....yrs.....mos.....ds.

(Signed) J O Hamilton M. D.

2-14-1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Groves cem Cemetery

DATE OF BURIAL: Feb 15 1920

20. UNDERTAKER: E Funk

ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 121

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28825

Registered No. 29

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot Ida (No. Maryland St.)

Registration District No.

Primary Registration District No. 2194

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evelyn Treasure

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 13 (Day) 1920 (Year)

7. AGE ....Yrs....Mos....ds.

IF LESS than 1 day how many ....hrs. or ....min.? 6

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Maryland Ida.

10. NAME OF FATHER John A. Treasure

11. BIRTHPLACE OF FATHER (State or Country) Ky.

12. MAIDEN NAME OF MOTHER Annie Alley

13. BIRTHPLACE OF MOTHER (State or Country) Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) X E W Hall

(Address) Maryland

15. Filed Feb 17 1920 Mrs Nellie E Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1920, to Feby 13 1920, that I last saw her alive on Feb 13 1920, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)

(Duration) .... yrs. .... mos. .... ds.

(Signed) H H Simmons M. D.

2/14 1920 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View Cem

DATE OF BURIAL Feb 1920

20. UNDERTAKER E Nye Monroe

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2104

(No. Maryland St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28826

Registered No. 21

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H Freeman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. — (Month) — (Day) 1841 (Year)

7. AGE: 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ky

10. NAME OF FATHER: Will Freeman

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Elizabeth —

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. Jones

(Address) Moreland.

15. Filed Feb-17 1912 Mr Hale E. Patrick Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24655

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 16 (Day) 1912 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1912, to Feb 16 1912, that I last saw h.. alive on Feb 16 1912 and that death occured on the date stated above, at 8 PM.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.

2/17 1912 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland | DATE OF BURIAL: Feb 19 1912

20. UNDERTAKER acting E. L. Jones | ADDRESS: Moreland

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 219
File No. 20821
Registered No. 92

1. PLACE OF DEATH
County of Bingham
City of Basalt
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wayne Nielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: July (Month) 10 (Day) 1919 (Year)

7. AGE: Yrs. 7 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Kimball Bingham Co. Ida.

10. NAME OF FATHER: Ammon E. Nielsen

11. BIRTHPLACE OF FATHER (State or Country): Soda Springs Idaho

12. MAIDEN NAME OF MOTHER: Thera Grandsen

13. BIRTHPLACE OF MOTHER (State or Country): Mt. Pleasant Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Taylor
(Address) Blackfoot R. 3

15.
Filed ..... 19.....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1920, to Feb. 17 1920, that I last saw h.im alive on Feb. 16 1920, and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:

Influenza. Pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. W. Tuck M. D.
2-17-1920 (Address) Basalt Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Basalt Idaho — DATE OF BURIAL: 2/19 1920

20. UNDERTAKER: Jesse M. Nielsen — ADDRESS: Basalt

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 21

Registration District No. 1007.

Primary Registration District No. .....

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28828

Registered No. 123

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Single

6. DATE OF BIRTH: Dec (Month) 19 (Day) 1918 (Year)

7. AGE: 1 Yrs. 1 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Alvy J. Williams

11. BIRTHPLACE OF FATHER (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Alice M. Main

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alvy J. Williams

(Address) Blackfoot Idaho

15. Filed Feb 17 1920 Mrs Nellie E. Watson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr. 12 1920 to Feb 17 1920, that I last saw her alive on Feb 17 1920, and that death occurred on the date stated above at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — Yrs. — mos. 6 ds.

Contributory (Secondary) Spanish influenza

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Joseph B Davis M. D.

2-17 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lone Ash Cemetery — DATE OF BURIAL ..... 19.....

20. UNDERTAKER E. Peck — ADDRESS Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28829

Registered No. 24

1. PLACE OF DEATH.

Registration District No. 107

Primary Registration District No. 2 96

County of Bingham

City of Blackfoot Odn (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beaulah Treasure

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.

(Month) unknown (Day) 1 (Year)

7. AGE

..... Yrs. 11 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bingham Co Idaho

10. NAME OF FATHER: John H Treasure

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Amia Allcey

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Silas Hall

(Address) Pocatello Ida.

15. Filed Feb 20 1920 W. Walter E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920, to Feb 19 1920, that I last saw her alive on Feb 19 1920 and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Dysentery

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.

2/20 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portland Ida — DATE OF BURIAL: 2-20 1920

20. UNDERTAKER: Silas Hall — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 28830
Registered No. 25

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Idaho Insane Asylum St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William F. Fairchild

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. February (Month) 19 (Day) 1920 (Year)

7. AGE: 60 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) as of our records here S. D. A. Donovan R. La'Reece
(Address) Blackfoot, Ida. Box 338

15. Filed 2-28 1920 Mrs Helen E. Patch Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-22 1919, to Febr-19- 1920 that I last saw h. im. alive on Febr-19- 1920 and that death occured on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:
Heart failure: Due to:- Dilatation and insufficiency of Mitro Valves & valvular lesion: General anasarca

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) 4 yrs. mos. ds.

(Signed) C. N. Owen M. D.
2/19-1920 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 3 mos. 29 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Parma, Idaho

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: 2-20 1920

20. UNDERTAKER: Robt King, Stewart Asylum — ADDRESS: Blackfoot, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28831
Registered No. 26

1. PLACE OF DEATH.
Registration District No. 121
Primary Registration District No. 1007
County of Bingham
City of Blackfoot (No. Rauch Mercan St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Calvin F Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 28 (Day) 1856 (Year)

7. AGE: 64 Yrs. 8 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Carolina

10. NAME OF FATHER: Lewis Johnson

11. BIRTHPLACE OF FATHER (State or Country): S C

12. MAIDEN NAME OF MOTHER: Nancy Whitley

13. BIRTHPLACE OF MOTHER (State or Country): S C

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. C. Johnson
(Address) Blackfoot

15. Filed 2-21 1920 Walter E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 1920, to Feb. 20 1920, that I last saw him alive on Feb. 20 1920, and that death occured on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) F. W. Mitchell M. D.

Feb. 1920 (Address) Blackfoot, Idaho.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rauch Walkersburgh N.C. DATE OF BURIAL: 191

20. UNDERTAKER: E J Peck ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BNDS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 2174

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28832

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot Ida (No. Shoreline St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Greaves

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. September 1 (Month) (Day) (Year)

7. AGE: 30 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky

10. NAME OF FATHER: — Alley

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: — Hall

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. L. Jones

(Address) Pr. Executor Blackfoot Ida Rt 2

15. Filed Feb 22 1920 Nora Nelson E. Pierce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920, to Feb 21 1920, that I last saw h.r alive on Feb 21 1920, and that death occured on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. Johnson M. D.

2/22 1920 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland | DATE OF BURIAL: 2/23 1920

20. UNDERTAKER: Acting E. L. Jones | ADDRESS: Moreland

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH 21

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28833
Registered No. 28

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot Ida (No. ..... Fresno St.)
Registration District No. .....
Primary Registration District No. 2194
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Owen Vernal Jensen.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Nov (Month) 12 (Day) 1919 (Year)

7. AGE
Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Vernal Jensen

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Anna Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Vernal Jensen
(Address) Blackfoot Idaho

15. Filed Feb 21 1920 Mrs Hallie E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1920 to Feb 21 1920, that I last saw h[illegible] alive on Feb 20 1920 and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Inflammation of small intestines (Enteritis)

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. J. Simmons M. D.
2/21 1920 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rich Idaho — DATE OF BURIAL: 2-22 1920

20. UNDERTAKER: E. Rich — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28834

Registered No. 29

Registration District No. 1 21

Primary Registration District No. 2 1

(No. Hosp. Insane Asy. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chalmer M Jacobs

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. October (Month) 18 (Day) 1892 (Year)

7. AGE: 29 Yrs. 4 Mos. 4 ds.

IF LESS than 1 day how many ..hrs. or ..min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Clerical work

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hailey Idaho

10. NAME OF FATHER: George H. Jacobs

11. BIRTHPLACE OF FATHER (State or Country): Canada Province

12. MAIDEN NAME OF MOTHER: Mary Jane M Faulkner

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) as of our office records. Donovan R. La Rees

Box 338 (Address) Blackfoot, Idaho

15. Filed Feb 25 1920 Wm. E. Parker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-17-1919, to Feb-23-1920, that I last saw him alive on Feb 23 1920, and that death occured on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Staticus epilepticus.

(Duration) Yrs. mos. ds.

Contributory (Secondary) Chronic epilepsy.

(Duration 4 Yrs. mos. ds.

(Signed) C. H. Hoyer M. D.

2-25 1920 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..yrs. 4 mos. 4 days. In the State 29 yrs. 4 mos. 4 days

Where was disease contracted if not at place of death?

Former or usual residence Hailey, Idaho

19. PLACE OF BURIAL OR REMOVAL: Hailey Idaho — DATE OF BURIAL: ..191..

20. UNDERTAKER: E. Funk — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28835

Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24

Primary Registration District No. 24 or 4

(No. Idaho Street Duncan Apartments)

2. FULL NAME Joseph Dowling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Cant say (Month) (Day) 1 (Year)

7. AGE: 41 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Cant say

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Cant say

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Records of Institution last we have

(Address) Cert'd Town

15.

Filed 2-24 1920 M. Tate E. Tate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1919, to Feb 23 1920, that I last saw him alive on Feb. 23 1920, and that death occured on the date stated above, at 5.45 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Sudden Apoplexy

Sudden

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Alcoholism & Syphilis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Cert'd Town M. D.

2/24 1920 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 7 mos. 23 days. In the State 17 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Cant say

Former or usual residence Boise, Ida

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: 2/24 1920

20. UNDERTAKER: L. L. Rossiter Acting — ADDRESS: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 127
Primary Registration District No. 2194
File No. 28836
Registered No. 27

1. PLACE OF DEATH
County of Bingham
City of Thomas Ida
(No. ..... St.) Empire
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Glen Roland Berg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M	white	Single

6. DATE OF BIRTH: Aug (Month) 31 (Day) 1915 (Year)

7. AGE: 4 Yrs. 5 Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Thomas Ida

10. NAME OF FATHER: Swan Berg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Lula Burk

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Swan Berg
(Address) RFD 1 - Aberdeen

15. Filed Feb. 23 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23/20 19..., to Feb 23/20 19..., that I last saw him alive on 2-23-20 19..., and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

(Duration) — Yrs. — mos. 1 ds.
Contributory (Secondary) Colec-Nephritis
(Duration) 2 yrs. — mos. — ds.

(Signed) Joseph B Davis M. D.
2/25 1920 (Address) Bellevue Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas-Riverside | DATE OF BURIAL: 2/24 1920

20. UNDERTAKER: Swan Berg | ADDRESS: Empire

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 28837
Registered No. 32

1. PLACE OF DEATH

County of Bingham
City of Blackfoot
(No. Dr Simmons Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME

Ruth Bickford Larkin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH

June (Month) 30 (Day) 1883 (Year)

7. AGE

36 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER E. E. Bickford

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Alice Arnold

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. F. Larkin

(Address) Blackfoot Idaho

15.

Filed Feb. 25 1920 M. Hallie E. Davis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920 to Feb 24 1920 that I last saw h[illegible] alive on Feb 24 1920, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) influenza

..... (Duration) ..... yrs. ..... mos. 12 ds.

(Signed) H. J. Simmons M. D.

2/26 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Frankfort Michigan	19

20. UNDERTAKER	ADDRESS
E. V. Peck	Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28830

Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot (Town or Precinct)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mackenie Van Orden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 11 (Day) 1920 (Year)

7. AGE: ....Yrs....Mos. 10 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jacob L. Van Orden

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Minnie Stubesand

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. L. Van Orden

(Address) Blackfoot R D #2

15. Filed Feb 24 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1920, to Feb 24 1920, that I last saw her alive on Feb 24 1920, and that death occured on the date stated above, at 1:30 P M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ~ Yrs. ~ mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

2/25 1920 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas Cemetery — DATE OF BURIAL: 2/24 1920

20. UNDERTAKER: J. L. Van Orden — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

[redacted] Bingham

CERTIFICATE OF DEATH

No. 121

District No. 2

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28840

Registered No. 95

City of [redacted] (No. [redacted], [redacted] St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christiane Michelson Bingham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 20 (Day) 882 (Year)

7. AGE: 37 Yrs. 5 Mos. [illegible] ds. 8

IF LESS than 1 day how many [illegible] hrs. or [illegible] min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Huntsville Utah

10. NAME OF FATHER: Jos. Hans Michelson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Bertha Lassen

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm H. Bingham.
(Address) Rockford,

15. Filed March 1 1920 Nora Hale E. Pitt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 28 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1920, to Feb 28 1920, that I last saw her alive on Feb 27 1920, and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:

Flu Pneumonia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Influenza & Endocarditis

(Duration) yrs. mos. 4 ds.

(Signed) W W Beck M. D.

2/28 1920 (Address) Blackfoot, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside Cem, — DATE OF BURIAL: 3-1 1920

20. UNDERTAKER: Ed L. Egli — ADDRESS: Blackfoot

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine.
City of Gannett. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022

File No. 28841
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Stanfield Nock.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female.	White.	married.

6. DATE OF BIRTH: June. (Month) 11th (Day) 1887 (Year)

7. AGE: 32 yrs. 8 mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~[illegible]~~, Idaho.

10. NAME OF FATHER: H. C. Stanfield.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Elizabeth Jenkins.

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. P. Nock.
(Address) Gannett.

15. Filed 2/10 1920 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 3rd (Day) 1920 (Year). Wright

17. I HEREBY CERTIFY, That I attended deceased from Jan. 15th 1920 to Feb 3rd 1920
that I last saw her alive on Feb 3rd 1920
and that death occurred on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:
Uremic Poisoning.
following Child-birth

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Bright's Disease
(Duration) 5 yrs. ..... mos. ..... ds.
(Signed) Robert H. Wright M. D.
2/4 1920 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Picabo. DATE OF BURIAL: 2-8 1920

20. UNDERTAKER: R. Harris. ADDRESS: Hailey - Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Bellevue
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022
(No. ..... St.)

File No. 28842
Registered No. 5
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas M. Bleel.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Dec. (Month) 7 (Day) 1835 (Year)

7. AGE: 84 yrs. 2 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X R. S. Dixon
(Address) Bellevue Ida.

15.
Filed 2-10 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 5th 1920 to Feb. 8th 1920
that I last saw him alive on Feb. 8 1920
and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 0 yrs. 3 mos. 7 ds.

Contributory (Secondary) Flu - 3

(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.
2/9 1920 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue, Ida — DATE OF BURIAL: 2-10 1920

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 7075
File No. 28843
Registered No. 6

1. PLACE OF DEATH.
County of Blaine
City of Carey
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Ellen Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 6 (Day) 1886 (Year)

7. AGE: 34 Yrs. 1 Mos. 3 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Labelle Idaho

10. NAME OF FATHER: Charles E Chase

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jane Dunn

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. L. Brown
(Address) Carey, Idaho

15. Filed 3-10 1920 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1920 to Feb. 1920, that I last saw her alive on Feb. 9 1920 and that death occured on the date stated above, at 3:20 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) Flu
(Duration ..... yrs. ..... mos. 3 ds.

(Signed) Houston E Snyder M. D.
19..... (Address) Carey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 3 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence Carey

19. PLACE OF BURIAL OR REMOVAL: Carey — DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER: at Carey Idaho — ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 28844
Registered No. 7

1. PLACE OF DEATH.
County of Blaine
City of Hailey (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Carlson -

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
March 27 (Month) (Day) 1843 (Year)

7. AGE
____ yrs. ____ mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Miners
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Finland -

10. NAME OF FATHER Carl Carlson -

11. BIRTHPLACE OF FATHER (State or Country) Finland

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Carlson
(Address) Hailey Ida

15.
Filed 2-10 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Wright
Feb 9 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-28 1920 to Feb-9 1920
that I last saw h alive on Feb 9 1920
and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) 2 yrs. ____ mos. 7 ds.
Contributory Flu
(Secondary)
(Duration) ____ yrs. ____ mos. 3 ds.
(Signed) Robert H. Wright M. D.
2/10 1920 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Hailey — DATE OF BURIAL 2-13 1920

20. UNDERTAKER J. E. Parkin — ADDRESS Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 28845
Registered No. 8

1. PLACE OF DEATH.
County of Klamath
City of Fetchum (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick Hyde

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, ~~MARRIED~~, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1839 (Year)

7. AGE: 80 yrs. 4 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mason
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Patrick Hyde

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Ruyter
(Address) Fetchum

15. Filed 3-10 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 10 (Day) 1919 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15, 1919, to Feb 11 1920, that I last saw him alive on Jan 20 1920 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) — yrs. — mos. — ds.
Contributory (Secondary) Arteriosclerosis
(Duration) 2 yrs. — mos. — ds.

(Signed) J. J. Plummer M. D.
19 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fetchum Ida. DATE OF BURIAL: Feb 13 1919

20. UNDERTAKER: R. D. Harris ADDRESS: Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Hailey,
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022

File No. 28846
Registered No. 9
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Claud Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Jan. (Month) 7 (Day) 1889 (Year)

7. AGE
30 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Mechanic
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kansas.

10. NAME OF FATHER A. Thompson.

11. BIRTHPLACE OF FATHER (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Eastwood.

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Colette Thompson
(Address) Hailey, Ida.

15.
Filed 3-10 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Diction
Feb 11 th 1920,
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1920 to Feb 11 1920,
that I last saw h[illegible] alive on Feb 11 1920,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory Influenza
(Secondary)
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) H. H. Talbot M. D.
Feb 11 1920 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Hailey, | DATE OF BURIAL: 2-13 1920

20. UNDERTAKER: R. O. Harris | ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28847

Registered No. 10

1. PLACE OF DEATH.

County of Blaine

City of Carey

(No. ....., ... St.)

Registration District No. 21

Primary Registration District No. 2025

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dawson Dale Patterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: girl

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Aug 10 1917 (Month) (Day) (Year)

7. AGE: 12 Yrs. 6 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah Co Utah

10. NAME OF FATHER Jas W Patterson

11. BIRTHPLACE OF FATHER (State or Country) Utah Co Utah

12. MAIDEN NAME OF MOTHER Jennie D Atwood

13. BIRTHPLACE OF MOTHER (State or Country) Utah Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jas W Patterson

(Address) Carey Blaine Co Idaho

15. Filed 3-10 1920 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 14 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920, to Feb. 14 1920, that I last saw her alive on Feb 14 1920 and that death occured on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 12 ds.

Contributory (Secondary) Flu

(Duration yrs. mos. 3 ds.

(Signed) Houston C Snyder M. D.

19.... (Address) Carey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.14 days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Carey Idaho

19. PLACE OF BURIAL OR REMOVAL: Carey — DATE OF BURIAL: Feb 15 1920

20. UNDERTAKER: at Carey Ida — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BOOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 28848
Registered No. 11

1. PLACE OF DEATH.
County of Blaine,
City of Gannett.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Myrl Nock.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Feb (Month) 18 (Day) 1920. (Year)

7. AGE: ..... yrs. ..... mos. 17 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Gannett.

10. NAME OF FATHER: Geo. F. Nock.

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Myrtle Stanfield

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. W. Stanfield
(Address) Gannett.

15. Filed 3-10 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Wright
Feb. (Month) 17. (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-1st 1920 to Feb 17 1920 that I last saw him alive on Feb 17 1920 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Mal-nutrition

(Duration) ..... yrs. ..... mos. 17 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.
2/15 1920 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paoli. DATE OF BURIAL: Feb 19 1920.

20. UNDERTAKER: O. S. Harris. ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M:1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine.
City of Hailey.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022

File No. 2885
Registered No. 13
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lilia A. Constock.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem'l.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Dec. 26. (Month) (Day) 1887. (Year)

7. AGE: 32 yrs. 1 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: G. McPhetes.

11. BIRTHPLACE OF FATHER (State or Country): Maine.

12. MAIDEN NAME OF MOTHER: Annie E. Roberts.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X C.W. Constock
(Address) Hailey, Idaho.

15.
Filed 3-1 1920 Robert H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Wright
Feb. (Month) 22nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 22 1920 to Feb. 22 1920 that I last saw h[illegible] alive on Feb. 22 1920 and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
1. Hemorrhages. Postpartum
- Child - birth

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary): Placenta Previa
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.
2/23 1920 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida. DATE OF BURIAL: 2/29 1920

20. UNDERTAKER: R.D. Harris. ADDRESS: Hailey, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 28851
Registered No. 1

1. PLACE OF DEATH.
County of Blaine
City of Bellevue (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Emma Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan. (Month) 2 (Day) 1853 (Year)

7. AGE: 67 yrs. 0 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: C. C. Herold

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Melvina Pennington

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Wilson
(Address) Bellevue Ida

15. Filed 2/1 1920 Robert H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-24 1920 to 1-30 1920
that I last saw her alive on 1-30 1920
and that death occurred on the date stated above, at 9 50 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary): Uremia

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) A. J. Wilson M. D.
1/31 1920 (Address) Bellevue Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue, Ida — DATE OF BURIAL: 2-1 1920

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey, Ida

BYMS - YORK CO., PRNS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

County of Blaine.

Primary Registration District No. 2022

File No. 2885

City of Hailey,

(No. ....., ... St.)

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chris Miller.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: about 1875
(Month) (Day) (Year)

7. AGE: 45 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Servia.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred. Haurand
(Address) Hailey

15.
Filed 2-1 1912 Robert H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Plumer.
Jan. (Month) 31 (Day) 1912 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1912 to Jan 31 1912, that I last saw h.. alive on Jan 31 1912 and that death occurred on the date stated above, at 1:35 M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) 3 yrs. — mos. — ds.

Contributory (Secondary) Lead Poisoning

(Duration) 3 yrs. mos. ds.

(Signed) J. J. Plummer M. D.

19 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey, Ida — DATE OF BURIAL: 2-1 1912

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey, Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 215-5
File No. 28859
Registered No. 1207

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME "Baby Hold"
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: January (Month) 31 (Day) 1920 (Year)

7. AGE: Yrs. Mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Russel McTaggart

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Helen Hold.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Bertha Wold
(Address) Sandpoint

15. Filed Feb 10 1920
FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 5 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 31 1920 to Feb 5 1920 that I last saw h[illegible] alive on Feb 5 1920 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Enumeration Convulsions
Premature birth

(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Convulsions existing

(Duration) yrs. mos. ds.

(Signed) C. F. Payne M. D.
1920 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida
DATE OF BURIAL: 2/8 1920

20. UNDERTAKER: E M Bowers
ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28860

Registered No. 1206

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

(No. ....., ... St.)

Registration District No. 78

Primary Registration District No. 215-3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Wold

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Apr (Month) 29 (Day) 1902 (Year)

7. AGE: 17 Yrs. 9 Mos. 6 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Telephone Operator

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Gulaows Wold

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Bertha Lunde

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Bertha Wold

(Address) Sandpoint Ida

15. Filed Feb 10 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1920, to Feb 5-m 1920, that I last saw h.e alive on Feb 5-m 1920, and that death occurred on the date stated above, at 5.30 P. M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

..... (Duration) unknown Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pregnancy

..... (Duration) 7 mos. 8 ds.

(Signed) O. A. Payne M. D.

Feb 10 1920 (Address) Sandpoint Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn.

DATE OF BURIAL: 2/8 1920

20. UNDERTAKER: Ed Bonner

ADDRESS: Sandpoint Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28861

Registered No. 1201

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

(No. ..... St.)

Registration District No. 78

Primary Registration District No. 215-1

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Josephine Skarland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 27 (Day) 1889 (Year)

7. AGE: 30 Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: N. Skarland

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Williams

(Address) Westmond Ida

15. Filed Feb 10 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920, to Feb 8 1920 that I last saw her alive on Feb 7 1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) C P Stackhouse M. D.

2/9 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 4 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Sandpoint

Former or usual residence Westmond

19. PLACE OF BURIAL OR REMOVAL: Westmond Idaho

DATE OF BURIAL: 2/9 1920

20. UNDERTAKER: E M Bowers

ADDRESS:

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28862

Registered No. 1204

Registration District No. 78

Primary Registration District No. 2155

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonner

City of Sandpoint

2. FULL NAME Bettel M Casler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 9 (Day) 1902 (Year)

7. AGE: 17 Yrs. 5 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): H S.

9. BIRTHPLACE (State or Country): S. Dak.

10. NAME OF FATHER: Geo F. Casler

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Minnie M. Oldt.

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo F. Casler
(Address) Glengary Ida.

15. Filed Feb. 10 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-17 1920, to Jan-17 1920, that I last saw h[illegible] alive on Jan-17 1920, and that death occured on the date stated above, at [illegible] P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis due to
ruptured Appendics
Septic.

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Hoyt E Wendle M. D.

1-19 1920 (Address) Sandpoint, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hope Ida — DATE OF BURIAL: 1/20 1920

20. UNDERTAKER: C M Brown — ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24659

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner

City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 2155

(No. ..... St.)

File No. 28864

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roger Bellmore Wmd.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 31 (Day) 1913 (Year)

7. AGE: 6 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: P. H. Bellmore

11. BIRTHPLACE OF FATHER (State or Country): N. Dak.

12. MAIDEN NAME OF MOTHER: Grace Miles

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. H. Bellmore
(Address) Coeur d'Alene Ida.

15. Filed Feb 10 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan - 22 1920 to Jan - 26 1920 that I last saw him alive on Jan - 25 1920, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Lesion

(Duration) 9 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Floyd Gilbreath M. D.

1/30 1920 (Address) Sandpoint Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: 1/28 1920

20. UNDERTAKER: [illegible] ADDRESS: SP

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 2153

(No. ..... St.)

File No. 28865

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Stanfield Quinn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 5 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. one ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: J. W. Quinn

11. BIRTHPLACE OF FATHER (State or Country): S. Dak.

12. MAIDEN NAME OF MOTHER: Stanfield Grady

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Quinn

(Address) City

15. Filed Feb 10 1920

FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan - 3 1920 to ..... 19—

that I last saw her alive on Jan - 3 1920

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH*, was as follows:

Acute Indigestion

.....

.....

.....(Duration) .....Yrs. .....mos. 1 ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) Floyd E. Wendle M. D.

1-8 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: 1/7 1920

20. UNDERTAKER: Bell Brower — ADDRESS: SP

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 81
Primary Registration District No.
(No. ....., ... St.)

File No. 28870
Registered No. 220

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonner
City of Jaclede

2. FULL NAME Floyd Culler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE

42 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Ind.

10. NAME OF FATHER Philip Culler

11. BIRTHPLACE OF FATHER

(State or Country) Ind

12. MAIDEN NAME OF MOTHER Alice Stanley

13. BIRTHPLACE OF MOTHER

(State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Floyd Culler
(Address) Post Falls, Ida.

15.

Filed Feb-7-1920 W R King Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29, 1920, **to** Feb 7, 1920, **that I last saw h.wa alive on** Feb 7, 1920 **and that death occured on the date stated above, at** 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Influenza

(Duration ..... yrs. ..... mos. 10 ds.

(Signed) W R King M. D.

Feb 8 1920 (Address) Jaclede Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	2-11 1920

20. UNDERTAKER	ADDRESS
R B Jones	Ada

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 85

Primary Registration District No. 2185

File No. 1 28871

Registered No. 10

County of Bonner

City of Priest River, Idaho. (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Ropp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH Dec 13, 1918
(Month) (Day) (Year)

7. AGE ..... Yrs. 1 3 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Floyd Ropp

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Ida Stover

13. BIRTHPLACE OF MOTHER (State or Country) West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Anthony Jilk

(Address) Priest River Ida

15. Filed Feb 14 1920 C. P. Getzloff
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 7 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1920 to Feb 7 1920, that I last saw him alive on Feb 7 1920, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary) Spanish Influenza

(Duration) — yrs. — mos. 4 ds.

(Signed) C. P. Getzloff M. D.

Feb 8 1920 (Address) PRIEST RIVER, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
PRIEST RIVER, IDAHO	Feb 8 1920

20. UNDERTAKER	ADDRESS
Wm Lewis	Newport Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 85
Primary Registration District No. 2185
File No. 20872
Registered No. 11

1. PLACE OF DEATH
County of Bonner
City of Priest River
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roy Taylor

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
January (Month) 5 (Day) 1884 (Year)

7. AGE
36 Yrs. ..... Mos. 1 ds. 7
IF LESS than 1 day how many ..... hrs. or 53 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Woodsman
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Minnesota Minn

10. NAME OF FATHER William Taylor

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Adelia Bennett

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Melissa Caplet
(Address) Priest River Idaho

15.
Filed Feb 14 1920 L. P. Gutzloff
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1920, to Feb 12 1920, that I last saw him alive on Feb 11 1920 19....., and that death occurred on the date stated above, at 1 A. M.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Spanish influenza

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) L. P. Gutzloff M. D.

Feb 13 1920 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Newport Wn	Feb 13 1920

20. UNDERTAKER	ADDRESS
Wm Lacy	Newport Wn

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 85
Primary Registration District No. 2185
File No. 128873
Registered No. 12

1. PLACE OF DEATH

County of Bonner
City of Priest River, Idaho.
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William John MacGillivray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec. (Month) not known (Day) 1868 (Year)

7. AGE: 52 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroad Construction
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): X Mrs R.O. Allen
(Address): 1906 College ave Spokane Wash

15. Filed Feb 14 1920 — C.P. Gutzloff, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1920, to Feb 11 1920, that I last saw him alive on Feb 11 1920, and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — Yrs. — mos. 5 ds.

Contributory (Secondary): Spinal Orthomyelitis

(Duration) — yrs. — mos. 7 ds.

(Signed) C.P. Gutzloff M. D.

Feb 11 1920 (Address) Priest River Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. 10 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Spokane, Wn.

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: Wm Doran — ADDRESS: Newport

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28874
Registered No. 13

1. PLACE OF DEATH
County of Bonner
City of Priest River,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 95
Primary Registration District No. 2195
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles J. CASSAP.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Greek
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 15 (Day) 1896 (Year)

7. AGE: 23 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberjack,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: John Cassap

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Mary Paskal

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George J Sugars
(Address) # 424 Trent Ave Spokane, Wash

15. Filed Feb 29 1920 C P Getzloff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 17 1920 (Day) (Year) 19....

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw him alive on ..... 19.....
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Accidental tree falling on chest and abdomen. Causeing instant death. Possible fracture at the base of the brain.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C P Getzloff M. D.
(Address) Feb 17 1920 Priest River,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Wm Davis — ADDRESS Newport, Wash.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28875

Registered No. 11

1. PLACE OF DEATH

County of Bonner

City of Newport

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 85

Primary Registration District No. 2185

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernestene Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: Sep (Month) 12 (Day) 1850 (Year)

7. AGE: 69 Yrs. 5 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Willia m Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Knowen

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Helen Heisner

(Address) Newport Idaho

15. Filed Feb 29 1920

C. P. Gotsch
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to Feb 23 1920

that I last saw her alive on Feb 22 1920

and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

and Senile weakness

(Duration) 1 Yrs. 2 mos. ..... ds.

Contributory (Secondary) delayed Senile weakness

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. S. Wallace M. D.

Feb 24 1920 (Address) Newport

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: William Davis

ADDRESS: Newport Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28878

Registered No. 14

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 21 v 0

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Bretches

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ?

6. DATE OF BIRTH: Aug. 6. 1836 (Month) (Day) (Year)

7. AGE: 83 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Bretches.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Mary Faust.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Thark

(Address) Lincoln Ida.

15. Filed Jan 17 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 3, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of lower lip & Jaw maxillary

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill

DATE OF BURIAL: Jan 5 1920

20. UNDERTAKER: H. H. Hays

ADDRESS: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2130
File No. 28880
Registered No. 16

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edmund Lee Gordon.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan. (Month) 3 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Leo,
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lincoln Ida

10. NAME OF FATHER: E J Gordon.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Annie E Latimer.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E J Gordon
(Address) Lincoln Ida

15. Filed Jan 12 1920 [signature] Local Registrar

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2. 1920, to Jan 3 1920
that I last saw h. alive on Jan 3 1920
and that death occurred on the date stated above, at 3 P.M.,
The CAUSE OF DEATH* was as follows: Pneumonia. Heart Lesion.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lincoln — DATE OF BURIAL: Jan 5 1920.

20. UNDERTAKER: [signature] Has no — ADDRESS: Idaho Falls

Dr Shupe

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH,
County of Bonneville
City of Ucon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2 1 1 - 0
(No. ....., ... St.)

File No. 28893
Registered No. 4
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Thomas Simmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Child

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1918 (Year)

7. AGE: 1 Yrs. 2 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ucon

10. NAME OF FATHER: Thomas E Simmons

11. BIRTHPLACE OF FATHER (State or Country): Ucon

12. MAIDEN NAME OF MOTHER: Florence Petersen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos E Simmons Sr.
(Address) Ucon Ida

15. Filed 2/13 1920 W Hammond Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1920, to Jan 28 1920, that I last saw him alive on Jan 25 1920, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Bronchial asthma -

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W C Shupe M. D.
1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ucon	1/27 1920

20. UNDERTAKER: C E Dewey ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Shupe

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 28894
Registered No. 44

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ichizo Hirabayashi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word.)

6. DATE OF BIRTH Feb. 2nd 1882
(Month) (Day) (Year)

7. AGE 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Labor
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Japan

10. NAME OF FATHER Eiji Hirabayashi

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Idaho Falls, Idaho.

15.

Filed ..... 19.....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 10 20
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 20, to Feb 10 20
that I last saw h[illegible] alive on Feb 10 20
and that death occurred on the date stated above, at 9:00 A.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 8 ds.

2/10 20 (Signed) [signature] M. D.

(Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL [illegible] **DATE OF BURIAL** Feb. 19 20

20. UNDERTAKER [signature] **ADDRESS** Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28897

Registered No. 41

1. PLACE OF DEATH

Registration District No. 73

Primary Registration District No. 2170

County of Bonneville

City of Idaho Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beula Pearl Boone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Child

6. DATE OF BIRTH: March ? 1916 (Month) (Day) (Year)

7. AGE: 3 Yrs. 10 Mos. ? ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Roy Bowen

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Flossie Sevier

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sevier
(Address) Ucon

15. Filed 2/18 1920 W Townsend Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 1 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1920 to Feb. 1, 1920 that I last saw her alive on Jan. 31, 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

Indefinite

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O Millar M. D.

2/4 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	2/4 1920
20. UNDERTAKER	ADDRESS
C C Dunwoody	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Dr Mellon

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 73

Primary Registration District No. 8170

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28898

Registered No. 46

1. PLACE OF DEATH

County of Bonneville

City of Moon

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Whitney Monroe Allen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Dec (Month) 18 (Day) 1911 (Year)

7. AGE: 8 Yrs. 1 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moon Ida

10. NAME OF FATHER: Edwin Allen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Minnie Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edwin Allen

(Address) Moon

15. Filed 2/1 1920 W Cummard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28, 1920 to Jan. 29, 1920 that I last saw h.r alive on Jan. 28 1920 and that death occurred on the date stated above, at 21 M.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Duration) Indefinite yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John O Miller M. D.

1/31 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moon Ida — DATE OF BURIAL: 1/31 1920

20. UNDERTAKER: C E Linnoodey — ADDRESS: Ida Falls

Dr Miller

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 28899
Registered No. 39

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Wood Johnson Jr
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 13 (Day) 1885 (Year)

7. AGE: 34 Yrs. 10 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer): Stock Raising

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Elmer W Johnson Sr

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary J Little

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer W Johnson Sr
(Address) Idaho Falls

15. Filed 2/17 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920, to Feb 12 1920, that I last saw him alive on Feb 12 1920, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jabez W Hall M. D.
2/17 1920 (Address) 206 Shupe Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls | DATE OF BURIAL: 2/15 1920

20. UNDERTAKER: Ellsworth | ADDRESS: Idaho Falls

FORM V. S. No. 5-75 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

28900

Registration District No. 73

Primary Registration District No. 21 V-0

File No.

Registered No. 38

1. PLACE OF DEATH

County of Bonneville

City of Ida Falls

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary M. B. Bocken

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April — 1885 (Month) (Day) (Year)

7. AGE: 34 Yrs. 10 Mos. ? ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Fredrick C Brown

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Charlotte Haynes

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O E Bocken

(Address) Ida Falls

15. Filed 2/14 19 20 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 15 19 20 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920 to Feb 15 1920 that I last saw h[illegible] alive on Feb 15 1920, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O E Shipp M. D.

19 ..... (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City — DATE OF BURIAL: 2/20 19 20

20. UNDERTAKER: E E Summersby — ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied, and should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28902
Registered No. 32

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 2107
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Patricia C. allphin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March 9 1907 (Month) (Day) (Year)

7. AGE: 13 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: Frank C allphin

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: alice Lundh

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank C allphin
(Address) Idaho Falls

15. Filed 2/7 1920 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 4 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1920 to Feb 4 1920 that I last saw her alive on 4th, Feb 1920 and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Tuberculosis of Spine
(Duration) 1 1/2 yrs. ..... mos. ..... ds.

(Signed) W. D. Griffin M. D.
2/7 1920 (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls | DATE OF BURIAL: Feb 19 20

20. UNDERTAKER: Coffelt Bros | ADDRESS: Idaho Falls

Dr. Jenkins.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28905

Registered No. 31

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

(No. ..... , ... St.)

Registration District No. 73

Primary Registration District No. 2103

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Ray Bench

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Aug (Month) 22 (Day) 1893 (Year)

7. AGE: 26 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ericplayer in
(b) General nature of industry, business or establishment in which employed (or employer): Sugar Mill

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Bench

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. R. Anderson
(Address) Idaho Falls

15. Filed 2/6 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Accidental: Fell from scaffold 15 ft striking head on cement floor fracturing skull
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. C. Dunwoody Coroner
2/6 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence ship

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City — DATE OF BURIAL: 2/7 1920

20. UNDERTAKER: C. C. Dunwoody — ADDRESS: Idaho Falls

D. Mellon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 0 0
(No. ..... St.)

File No. 28904
Registered No. 34

1. **PLACE OF DEATH**

County of Bonneville
City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Dowced Slighton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: male

4. **COLOR OR RACE**: white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): single

6. **DATE OF BIRTH**: Jan (Month) 23 (Day) 1920 (Year)

7. **AGE**: ..... Yrs. ..... Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. **BIRTHPLACE** (State or Country): Miles West Idaho Falls

10. **NAME OF FATHER**: James Slighton

11. **BIRTHPLACE OF FATHER** (State or Country): Mo.

12. **MAIDEN NAME OF MOTHER**: Eva Mathews

13. **BIRTHPLACE OF MOTHER** (State or Country): Idaho.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) J W Slighton
(Address) Idaho Falls Ida

15. Filed 2/4 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Feb (Month) 1 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 1-30-1920 to 2-1-1920 **that I last saw h— alive on** 1-30-1920 **and that death occurred on the date stated above, at** —M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hollister M. D.

19..... (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Rose Hill Idaho Falls

DATE OF BURIAL ..... 19.....

20. **UNDERTAKER**: Cliff Hayes

ADDRESS: Idaho Falls

Dr Hollister

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No. 2170
File No. 28906
Registered No. 32

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva May Bodily

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feby (Month) 14 (Day) 1880 (Year)

7. AGE: 39 Yrs. 11 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Patterson Dels Griffith

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Sarah Gibson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eva May Bodily
(Address) Iona, Idaho

15. Filed Jan 31 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12 1920, to Jan. 16 1920, that I last saw her alive on Jan. 16 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Shock from hemorrhage Dad delivery
placenta praevia.
(Duration) ..... Yrs. 4 mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O'Mellon M. D.
1/19 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iona, Ida. — DATE OF BURIAL: 1/20 1920

20. UNDERTAKER: E. Dinwoodey — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

J. O'Mellon

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 28909
Registered No. 29

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls.
(No. Yellowstone Ave., St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christina Andersen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Oct (Month) 30 (Day) 1841 (Year)

7. AGE: 79 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden.

10. NAME OF FATHER: Mongerson.

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Christina Mongerson.

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred Henderson.
(Address) Box 84 Idaho Falls Ida.

15. Filed Jan 26 1920 W. M. Lamond Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 27, (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12, 1920 to Jan. 27, 1920 that I last saw h.. alive on Jan. 20, 1920 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Acute gastritis

(Duration) ... Yrs. ... mos. 14 ds.

Contributory (Secondary) —

(Duration) ... yrs. ... mos. ... ds.

(Signed) John O. Mellor M. D.

19 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: Jan 25 1920

20. UNDERTAKER: Leffler & Co — ADDRESS: Idaho Falls

For Mellor.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 28910
Registered No. 24

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls
(No. Cor. 4th & Emerson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Methy.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan. 31 (Month) (Day) 1920 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many 6 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls.

10. NAME OF FATHER: Frank Methy

11. BIRTHPLACE OF FATHER (State or Country): Syria

12. MAIDEN NAME OF MOTHER: Rachel Nakin

13. BIRTHPLACE OF MOTHER (State or Country): Syria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mike Methy
(Address) Box 4 Idaho Falls Ida

15. Filed Jan 22 1920 Wm Tennant Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. 31 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920 to Jan 21 1920 that I last saw h[illegible] alive on Jan 21 1920 and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Premature Infant
Six and a half months.

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos....ds.

(Signed) Harry L. Milhan M. D.

1/22 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL / DATE OF BURIAL
Pine Hill Cemetery Jan 23 1920

20. UNDERTAKER: [illegible] ADDRESS: Idaho Falls

Dr. Weber

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28911

Registered No. 27

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 21 J-D

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary M. St John

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: April (Month) 12 (Day) 1842 (Year)

7. AGE: 77 Yrs. 9 Mos. 8 Ds.

IF LESS than 1 day how many ..... hrs. or 5 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Ezra Crofutt

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Mary Crofutt

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. B St John

(Address) Ida Falls, Ida

15. Filed Jan 16 19 20 C H Armand Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 13, (Day) 1920 (Year)*

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1919, to Jan 13 1920 that I last saw h[illegible] alive on Jan 13 1920 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A D Armand M. D.

Jan 14 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rest Haven Ida — DATE OF BURIAL: Jan 17 1920

20. UNDERTAKER: C. Hyer — ADDRESS: Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28919

Registered No. 3

1. PLACE OF DEATH

County of Bannock

City of Last Town

(No. ....., ... St.)

Registration District No. 73

Primary Registration District No. 2102

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geddie Grayson Satterfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Sept (Month) 1 (Day) 1895 (Year)

7. AGE: 74 Yrs. 4 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: J. Satterfield

11. BIRTHPLACE OF FATHER (State or Country): Ala.

12. MAIDEN NAME OF MOTHER: Johanna Blakney

13. BIRTHPLACE OF MOTHER (State or Country): Ala

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marvin C. Thompson
(Address) 369 Basalt St Idaho Falls

15. Filed Jan 10 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1919, to Jan 9 1920, that I last saw him alive on Jan 9 1920, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Cerebral Thrombosis following operation for mastoid.

(Duration) Yrs. 1 mos. 7 ds.

Contributory (Secondary) Chronic otitis media

(Duration) 15 yrs. ..... mos. ..... ds.

(Signed) Ralph T. Merrill M. D.

Jan 10 1920. (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Ship

19. PLACE OF BURIAL OR REMOVAL: Pocatello, Ida. DATE OF BURIAL: 1/12 1920

20. UNDERTAKER: C C Dunwoody ADDRESS: Ida Falls

Dr Merrill

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 216
File No. 28922
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

2. FULL NAME Antone J. Rudd

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 19 (Day) 1865 (Year)

7. AGE: 05 Yrs. 5 Mos. 13 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Grader
(b) General nature of industry, business, or establishment in which employed (or employer): Sawmill

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: J. Dell Rudd

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Gunhild Marie Syvertson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Antone Rudd
(Address) .....

15. Filed 1/3/30 191.... E. E. Fry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ... Jan (Month) 2 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1930 to ....191...
that I last saw him alive on Jan. 2nd. 1930
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

acute dilatation of heart.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Endocarditis

(Duration) 1 Yrs. ..... mos. ..... ds.

(Signed) E. E. Fry M. D.
1/3/1930 (Address) Bonners Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: Jan 5 1930

20. UNDERTAKER: O'Rourke — ADDRESS: Bonners Ferry Ida

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 79

Primary Registration District No. 3156

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28923
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Boundary

City of Bonners Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Viola C. Dionne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 1 (Day) 1886 (Year)

7. AGE: 33 Yrs. 6 Mos. 11 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John K. Grayson

11. BIRTHPLACE OF FATHER (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Minnie D. Couvrier

13. BIRTHPLACE OF MOTHER (State or Country): New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred Dionne
(Address): Bonners Ferry Ida

15. Filed Jan. 13 1920.

E E Fry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10 1919 to Jan. 12 1920
that I last saw h. alive on Jan. 10 1920
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 (2) Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.

1/12 1920 (Address) Bonners Ferry

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 1/15 1920

20. UNDERTAKER: C. A. Stookey — ADDRESS: Bonners Ferry Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28924
Registered No. .....

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79
Primary Registration District No. 515-6
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter A. Rookey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	

6. DATE OF BIRTH. Feb (Month) 7 (Day) 1858 (Year)

7. AGE 61 Yrs. 6 Mos. 10 ds. IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry, business, or establishment in which employed (or employer) Bonner mill

9. BIRTHPLACE (State or Country) St Regis Ont.

10. NAME OF FATHER Daniel Rookey

11. BIRTHPLACE OF FATHER (State or Country) Mill Rush Ont.

12. MAIDEN NAME OF MOTHER Hannah Amelia

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. O. Rookey
(Address) Bonners Ferry

15. Filed 1/19/ 1920. E E Fry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Acute dilatation of heart (b)
(Death instantaneous)

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory .....
(Secondary)

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) E E Fry M. D.
1/17/1920. (Address) Bonners Ferry

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Ida — DATE OF BURIAL Jan 19.... 1920

20. UNDERTAKER O'Rookey — ADDRESS Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28925
Registered No. .....

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79
Primary Registration District No. 3-B-6
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Floyd Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	

6. DATE OF BIRTH. Feb (Month) 4 (Day) 1916 (Year)

7. AGE 14 Yrs. 1 Mos. 13 ds. IF LESS than 1 day how many .... hrs. or .... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. F Hansen

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Huldah Edwards

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Hansen
(Address) Bonners Ferry Ida

15. Filed 3/17/ 1930. [illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 17 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 10 1930 to Mar. 17 1930 that I last saw him alive on Mar. 16 1930 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Peritonitis

.....(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Influenza - Pneumonia

.....(Duration) ..... Yrs. ..... mos. 10 ds.

(Signed) [illegible] M. D.

3/17/1930 (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Ida — DATE OF BURIAL Mar. 20. 1930

20. UNDERTAKER [illegible] — ADDRESS Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28926
Registered No. .....

Registration District No. 79
Primary Registration District No. 3156

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eric F. Henige

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 4 (Day) 1874 (Year)

7. AGE: 45 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Daniel Shultz

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry J. Henige
(Address) .....

15. Filed 3/ 1920. [illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h...alive on ..... 191...
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goitre.

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E. E. Fire M. D.
3/27 1920. (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 1-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 59

County of Butte

Primary Registration District No. 2129

File No. 28927

City of Arco (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Nations

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov 15 (Month) (Day) 1885 (Year)

7. AGE: 35 Yrs. 3 Mos. 12 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mayen Co Mo

10. NAME OF FATHER: Johnson H. Morris

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Jane Ferson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Morris

(Address) Arco Ida

Filed 1/3 1920

E W Fox
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 3 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/27 1919, to 1/3 1920, that I last saw h er alive on 1/3 1920, and that death occured on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) 2 Mo Pregnancy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E W Fox M. D.

1/3 1920 (Address) Arco, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moore, Idaho

DATE OF BURIAL: 1/5 1920

20. UNDERTAKER: E. H. Hendrick

ADDRESS: Arco, Ida

IN FAMILY, WITH UNDERLYING ETIOLOGY. PHYSICIANS MAKING REPORT FOR BUREAU OF VITAL STATISTICS. THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. Exact address of DECEASED in plain terms, so that it may be properly classified. DATE OF DEATH is very important. See instructions on back of certificate. NAME OF OCCUPATION

H. R. 2

STATE PRINTING CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2129
File No. 28928
Registered No.

1. PLACE OF DEATH
County of Butte
City of Howe
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Rodgers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 3 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 20 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Howe, Idaho

10. NAME OF FATHER: Earl Rodgers

11. BIRTHPLACE OF FATHER (State or Country): Darlington, Idaho

12. MAIDEN NAME OF MOTHER: Helen Koch

13. BIRTHPLACE OF MOTHER (State or Country): St Paul Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Rodgers
(Address) Howe Idaho

15. Filed Jan 4 1920 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1920, to Jan 4 1920, that I last saw him alive on Jan 4 1920, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Anemia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

1/4 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Howe, Idaho — DATE OF BURIAL: 1/5 1920

20. UNDERTAKER: Earl Rodgers — ADDRESS: Howe, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V[redacted]5-25 M. 1-19.

CERTIFICATE OF DEATH

S[redacted] Idaho
BOARD[redacted] HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 21 29
File No. 28929
Registered No.

1. PLACE OF DEATH
County of Butte
City of Moore
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nels Martin Levin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Nov. (Month) 29 (Day) 1838 (Year)

7. AGE: 81 Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Shoemaker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nels N. Levin Jr
(Address) Moore Ida

15. Filed 1/8 19 20 E. W. Fox Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8 1920 to Jan 8 1920
that I last saw h[redacted] alive on Jan 8 1920,
and that death occurred on the date stated above, at 1 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. W. Fox M. D.
1/8 1920 (Address) Moore Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ogden Utah	1/12 1920

20. UNDERTAKER	ADDRESS
Clifford C Hayes	Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28930
Registered No. .....

1. PLACE OF DEATH.
County of Butte
City of Moore
(No. ....., ... St.)
Registration District No. 59
Primary Registration District No. 12, 29
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Knutson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 1 (Month) 23 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Moore, Idaho

10. NAME OF FATHER John J. Knutson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Rosalia A. Jefferson

13. BIRTHPLACE OF MOTHER (State or Country) Geneva Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John J. Knutson
(Address) Moore, Idaho

15. Filed 2/24 1920 — E. W. Fox, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-23 1920, to 1/24 1920, that I last saw her alive on 1/24 1920 and that death occured on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E. W. Fox M. D.
1/24/20 (Address) Moore, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Moore, Idaho — DATE OF BURIAL 1/25 1920

20. UNDERTAKER John J. Knutson — ADDRESS Moore, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28931
Registered No. 1...4...

Registration District No. 59
Primary Registration District No. 2129

1. PLACE OF DEATH
County of Butte
City of Arco
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)

2. FULL NAME Cynthia Gilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH. Sept 4 (Month) 4 (Day) 1846 (Year)

7. AGE: 74 Yrs. 6 Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Edward Gilson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Cynth Drake

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. M. Gaines
(Address) Arco Ida

15. Filed 2/6 1920 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 6 (Month) Fri (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920 to Feb 6 1920
that I last saw her alive on Feb 6 1920
and that death occurred on the date stated above, at 952 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Spanish Influenza
(Duration) ..... Yrs. ..... mos. 4 ds.

(Signed) O. M. Gaines M. D.
2/6 1920 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 6 mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death? .....
Former or usual residence Arco Ida

19. PLACE OF BURIAL OR REMOVAL: Corinne Ida — DATE OF BURIAL: 2/10 1920

20. [redacted] — ADDRESS: Arco

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 1-25 M. 1-19.

CERTIFICATE OF DEATH

28792

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No. 2 pt A
File No. 31
Registered No. 3195

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 340 No Arthur St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thos J Blythe
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Dec. (Month) 23 (Day) 1885 (Year)

7. AGE: 34 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Plumber
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bancock Mich

10. NAME OF FATHER: Ed Blythe

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Katie Bayton

13. BIRTHPLACE OF MOTHER (State or Country): Okeboygan Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Katie Blythe
(Address) 340 No Arthur

15. Filed Feb 4 19[illegible] O P Steely
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 - 1920 to Feb 3 - 1920
that I last saw him alive on 2/3 1920,
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia & Rash
Lungs —
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Lynn M. D.
Feb 3 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mackay Ida — DATE OF BURIAL: 2/5 1920

20. UNDERTAKER: W. H. Tucker — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STAR-YORK CO. PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2129
File No. 2933
Registered No. 163

1. PLACE OF DEATH
County of Butte
City of Arco
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Griffith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec. (Month) 27 (Day) 1853 (Year)

7. AGE 66 Yrs. 1 Mos. 18 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner Supt.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Berlin Wis

10. NAME OF FATHER Richard Griffith

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Pugh

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. W. McFarland
(Address) Arco Ida

15. Filed 2-7 1920 E. W. McFarland Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1920 to Feb. 7th 1920 that I last saw h.... alive on ..... 191.... and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Strangulated inguinal hernia - left side
(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) none
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E. W. McFarland M. D.
2/9 1920 (Address) Arco Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Gateway Ida. DATE OF BURIAL 2/11 1920

20. UNDERTAKER E. W. McFarland ADDRESS Arco Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28934
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 59
Primary Registration District No. 2129
(No. ....., ... St.)

1. PLACE OF DEATH
County of Butte
City of Arco
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loren Alvin Crow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH. March (Month) 27th (Day) 1892 (Year)

7. AGE 27 Yrs. 10 Mos. 14 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep herder
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Lake - Ida.

10. NAME OF FATHER Joseph Loren Crow

11. BIRTHPLACE OF FATHER (State or Country) Montana

12. MAIDEN NAME OF MOTHER Mary E. Steed

13. BIRTHPLACE OF MOTHER (State or Country) Farmington Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr E.R. McHan
(Address) Arco

15. Filed 2/12 1920 — E W Ft — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/5 1920 to 2/10 1920
that I last saw him alive on 2-10 1920
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Lobular Pneumonia
(Broncho)
.....
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Influenza
(Duration) ..... Yrs. ..... mos. 7 ds.

(Signed) E W Ft M. D.
2/12 1920 (Address) Arco Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Arco, Ida. — **DATE OF BURIAL** 2-12 1920

20. UNDERTAKER E.R. McHan — **ADDRESS** Arco, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Butte

County of Blaine

City of Howe

Registration District No. 59

Primary Registration District No. 2129

(No. ....., ... St.)

File No. 28935

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Wilbur Wilde

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 9 (Day) 1919 (Year)

7. AGE: Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jens N Wilde

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Marie Gregersen

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jens Wilde

(Address) Howe, Idaho

15. Filed 2/11 1920 Ein Fot Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/8 1920 to 2/11 1920, that I last saw him alive on 2/11 1920 and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ein Fot M. D.

2/13 1920 (Address) Howe, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Howe, Idaho — DATE OF BURIAL: 2/13 1920

20. UNDERTAKER: Jens Wilde — ADDRESS: Howe, Idaho

SYMS - YORK CO., PTRS. & BDRS. 24658

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28936
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 59
Primary Registration District No. 2129
(No. ....., ... St.)

1. PLACE OF DEATH
County of Butte
City of Arco
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rollin P. Toland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec. (Month) 28 (Day) 1880 (Year)

7. AGE: 39 Yrs. 1 Mos. 17 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Grand Rapids Michigan

10. NAME OF FATHER: J S Toland

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Dora Weavers

13. BIRTHPLACE OF MOTHER (State or Country): Grand Rapids Mich

14. I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. & R. McFarland
(Address) Arco Ida.

15. Filed 2/24 1920 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/6 1920 to 2/24 1920 that I last saw him alive on 2/24 1920 and that death occurred on the date stated above, at 12 3 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Hemorrhage
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributor (Secondary) Acute Miliary Tuberculosis
.....(Duration) .... Yrs..... mos. 10 ds.
(Signed) E. W. Fox M. D.
2/24 1920 (Address) Arco Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco Idaho — DATE OF BURIAL: Feb. 26 1920

20. UNDERTAKER: R. L. & R. McFarland — ADDRESS: Arco Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2036
File No. 28938
Registered No. ____

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma M. Theile
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 22 (Day) 1857 (Year)

7. AGE: 62 Yrs. 6 Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Henry Bethin

11. BIRTHPLACE OF FATHER (State or Country) Germany.

12. MAIDEN NAME OF MOTHER Gina

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. C. Baldwin
(Address) Spokane W.

15. Filed Feb. 25 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9th 1920, to Feb. 18th 1920, that I last saw h ex alive on Feb 16th 1920, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary)
(Duration ____ yrs. ____ mos. ____ ds.

(Signed) Thos. E. Nangle M. D.
2-24 1920 (Address) Thos E Nangle MD

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kolbenlawn Cem. DATE OF BURIAL: 2-20 1920

20. UNDERTAKER: F. K. Robinson ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2004
File No. 28939
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John C. Loomis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. May (Month) 16 (Day) 1 (Year)

7. AGE 17 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm Loomis

11. BIRTHPLACE OF FATHER (State or Country) Ore

12. MAIDEN NAME OF MOTHER Minnie Gubbe

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Wm Loomis
(Address) Melba Idaho

15. Filed Feb. 25 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31st 1920, to Feb 18th 1920, that I last saw h[illegible] alive on Feb 18th 1920, and that death occured on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows: "Flu"
Empyema following
Pneumonia

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Thos E. Mangum M. D.
2-21 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Melba Cem | DATE OF BURIAL 2-19 1920

20. UNDERTAKER H. C. Robinson | ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

7

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1006
(No. , St.)

File No. 28940
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Weaver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem	White	Married

6. DATE OF BIRTH
Sept (Month) 2 (Day) 1842 (Year)

7. AGE
77 yrs. 6 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work House Keeper
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ind a

10. NAME OF FATHER Chas Blake

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Weaver
(Address) Nampa Idaho

15. Filed Feb. 25 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920 to Feb 16 1920
that I last saw h er alive on Feb 16 1920
and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:
Uraemia

(Duration) — yrs. — mos. 10 hours
Contributory (Secondary) Chronic Heart Disease
(Duration) yrs. mos. ds.

(Signed) Leo M. Chilton M. D.
19 (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mennonite Cem — DATE OF BURIAL 2-18 1920

20. UNDERTAKER F. F. Robinson — ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28941
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. Nampa
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1921 (Year)

7. AGE: 60 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ga.

10. NAME OF FATHER: H. P. Jay

11. BIRTHPLACE OF FATHER (State or Country): Ga.

12. MAIDEN NAME OF MOTHER: Nancy Waters

13. BIRTHPLACE OF MOTHER (State or Country): Ga.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. P. Jay
(Address) Nampa Idaho

15. Filed Feb. 25 1920 Pearle Dodds. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920, to Feb 16th 1920, that I last saw her alive on Feb 16th 1920, and that death occured on the date stated above, at 4:45 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia, Secondary to Flu
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Thos E Mahaffey M. D.
2-24-1920 (Address) Thos E Mahaffey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlenberger Cem. — DATE OF BURIAL: 2-19 1920

20. UNDERTAKER: H. T. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28942

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Bowmont

Registration District No. 7

Primary Registration District No. 2006

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W. Marek

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb. (Month) 12 (Day) 1917. (Year)

7. AGE: 3 Yrs. ..... Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank Marek.

11. BIRTHPLACE OF FATHER (State or Country) Bohemia

12. MAIDEN NAME OF MOTHER Lanik.

13. BIRTHPLACE OF MOTHER (State or Country) Bohemia.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Marek.

(Address) Bowmont. Ida.

15. Filed Feb. 25 1920 Pearle Dodd Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23. 1920, to Dec call 191..., that I last saw him alive on Feb 23. 1920 and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria -

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Smith M. D.

2/26 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 2-25 1920

20. UNDERTAKER: F. N. Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTGS. & ENGS. 246548

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 1106

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28913

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

(No. Sisters of Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irene Hannifin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: August 17 (Month) (Day) 1898 (Year)

7. AGE: 21 Yrs. 5 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: Jerry Hannifin

11. BIRTHPLACE OF FATHER (State or Country): Boston Mass

12. MAIDEN NAME OF MOTHER: Mary Collins

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): John B. Hannifin

(Address): 1109 - 8 Front St

15. Filed Feb. 14 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr. (Month) 11th (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 21st 1919, to Febr. 11th 1920 that I last saw her alive on Febr. 11th 1920 and that death occurred on the date stated above, at 5.20 P.M.

The CAUSE OF DEATH* was as follows:

Oedema of lungs following ureterotomy for impacted calculus.

(Duration) 8 Yrs. 1 mos. 21 ds.

Contributory (Secondary) Satarrh influenza.

(Duration) 1 yrs. 4 mos. 0 ds.

(Signed) Geo. A. McKellogg M. D.

19..... (Address) Nampa, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Boise Ida

DATE OF BURIAL: Feb 13 1920

20. UNDERTAKER: Schreiber & Sickenberger

ADDRESS: Boise

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 2006

File No. 28944
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alberta May Otten

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Feb (Month) 10 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: I
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Vernon Otten

11. BIRTHPLACE OF FATHER (State or Country): Nebr

12. MAIDEN NAME OF MOTHER: Leona Nice

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Pete Mc Cookum
(Address) Nampa Ida

15. Filed Feb. 18 1920 Pearle Dodds. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10 1920, to Feb 13 1920, that I last saw her alive on Feb. 13 1920 and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from Alimentary Canal - Cancer of Stomach

(Duration) ..... yrs. mos. 5 ds.
Contributory (Secondary) Premature Birth
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. R. Proctor M. D.
19 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 2/15 1920

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Proctor

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

File No. 28945

County of Canyon

City of Melba

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Ray Doramus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: Feb (Month) 20 (Day) 1917 (Year)

7. AGE: 2 yrs. 11 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER C. F. Doramus

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Jessie McMullen

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. F. Doramus

(Address) Melba

15. Filed Feb. 18 1920 Pearle Dodds, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jul (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-6-1920, to 7-11-1920 that I last saw h[illegible] alive on 7-11-1920 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) Dysentery

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. J. Coleman M. D.

7-14-1920 (Address) Kuna Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs .....mos .....days. In the State .....yrs .....mos .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rochester

DATE OF BURIAL: 7-13-1920

20. UNDERTAKER: F. M. Robinson

ADDRESS: Nampa Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

County of Canyon

Primary Registration District No. 1006

File No. 28946

City of Nampa (No. 603, 16th ave, St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hermon Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 12 (Month) 25 (Day) 1878 (Year)

7. AGE: 41 yrs. 1 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blind.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Stewart, Iowa.

10. NAME OF FATHER: Edmond Miller

11. BIRTHPLACE OF FATHER (State or Country): Vermont.

12. MAIDEN NAME OF MOTHER: Canada

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Harold Miller
(Address) Nampa Idaho

15. Filed Feb. 18 1920 Pearle Dodds, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12 1920, to one call ~~1919~~, that I last saw him alive on Jan. 12 1920 and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) 6 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. B. Smith M. D.

2/14 1920 (Address) Nampa Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho | DATE OF BURIAL: Feb. 17 1920

20. UNDERTAKER: F. R. Robinson | ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28947
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ..... St.)
Registration District No. 7
Primary Registration District No. 2006
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjiman F Hixson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Oct (Month) 22 (Day) 1904 (Year)
7. AGE: 16 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ore
10. NAME OF FATHER: Benjiman F Hixson
11. BIRTHPLACE OF FATHER (State or Country): Kansas
12. MAIDEN NAME OF MOTHER: Cora B Hanton
13. BIRTHPLACE OF MOTHER (State or Country): Kansas
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) B F Hixson
(Address) Nampa
15. Filed Feb. 25 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
X Feby. (Month) 4 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920, to Feby 3 1920, that I last saw him alive on Feby 3rd 1920, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: X
"Flu"
..... (Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Pneumonia
..... (Duration ..... yrs. ..... mos. 2 ds.
(Signed) J W Hamer M. D.
19..... (Address) Middleton Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Roeheleawn Cem. DATE OF BURIAL: 2-6 1920
20. UNDERTAKER: H K Robinson ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28948

Registered No. .....

1. PLACE OF DEATH.

County of Clearwater

City of Kamiah

Registration District No. 7

Primary Registration District No. 1006

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Hixson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1857 (Year)

7. AGE: 63 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: Hotel Keeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: R. G. Hixson

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Loreane Millage

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) B. F. Hixson

(Address) Kamiah Ida.

15. Filed Feb. 24 1920 Pearle Dodds. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14 1920, to Feb. 18 1920, that I last saw him alive on Feb. 18 1920, and that death occured on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo. R. Proctor M. D.

19..... (Address) Kamiah, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Delta Colorado

DATE OF BURIAL: Feb 21 1920

20. UNDERTAKER

ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24854

Proctor

Proctor

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 28949
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anita Carter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan. (Month) 26 (Day) 1858 (Year)

7. AGE: 62 yrs. mos. 19 ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Provo Utah

10. NAME OF FATHER: Edson Whipple

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Mary N—

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. W. Carter
(Address) Nampa, Ida.

15. Filed Feb. 24 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920, to Feb 15 1920, that I last saw h[illegible] alive on Feb 15 1920, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Carcinoma of bowel

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. 6 mos. ds.

(Signed) F. P. Smith M. D.
2/16 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Interment Immediate Cem. DATE OF BURIAL: 2-18 1920

20. UNDERTAKER: F. T. Reed & Sons ADDRESS: Nampa

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Smith

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 28950
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas E. Knapp.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
June (Month) 1 (Day) 1836 (Year)

7. AGE
73 yrs. 9 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Jane Westbrook

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C. E. Knapp.
(Address) Nampa Ida.

15.
Filed Feb. 18 1920 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1920, to Feb 15 1920, that I last saw h im alive on Feb 15 1920 and that death occurred on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(Duration) 1 yrs. — mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. F. Tellon M. D.
2/16 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rochelawn	2-17 1920

20. UNDERTAKER	ADDRESS
F. K. Robinson	Nampa

McLellan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 28951
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dykhuis Jantje Klugheit

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 68 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

No other information

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. H. Miller
(Address) Nampa Ida

15. Filed Feb. 24 1920 Pearle Dodds, Local Registrar

BYRNS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1920, to Feb 12 1920, that I last saw her alive on Feb 12 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency
and acute dilatation of
the heart

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Coleman M. D.
2-16 1920 (Address) Kuna Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rohlerdawn Cem. — DATE OF BURIAL: 2-18 1920

20. UNDERTAKER: F. T. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 28953
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME T.R.Lupton.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Febr; (Month) 19 (Day) 1851 (Year)

7. AGE: 68 yrs. 11 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER James Lupton.

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Jane Fisher

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs.T.R.Lupton.
(Address) Nampa Idaho.

15. Filed Feb. 25 1920 Pearle Dodds. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1919, to Feb 11 1920, that I last saw him alive on Feb 11 1920, and that death occurred on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 3 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.P.Murray M. D.
2-12-1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Koehlerlawn Cem.	2/13/1920

20. UNDERTAKER	ADDRESS
F.K.Robinson.	Nampa Ido.

SYMS - YORK CO., PTRS. & BDRS. 19760

(Murray.)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1806
(No. ....., ... St.)

File No. 28954
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gladys May Bates

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fem	White	

6. DATE OF BIRTH: May (Month) 22 (Day) 1919 (Year)

7. AGE: 10 yrs. 10 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nash Okl.

10. NAME OF FATHER: Edward E. Bates

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Bertie M.

13. BIRTHPLACE OF MOTHER (State or Country): W. Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Bates
(Address) Nampa Ida

15. Filed Feb. 25 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7th 1920, to Feb. 15th 1920, that I last saw her alive on Feb. 14 1920, and that death occurred on the date stated above, at A M.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar type

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos E. Manguam M. D.
2-17 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rosedale Cem. DATE OF BURIAL: 2-16 1920

20. UNDERTAKER: F. T. Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Manguam

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2007

File No. 28955

County of Canyon

City of Parma (No. ....., ... St.)

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Robert Goddard

If death occured in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M	W	S (*Write* the word.)

6. DATE OF BIRTH: Jan (Month) 3 (Day) 1920 (Year)

7. AGE: ..... yrs. 1 mos. 3 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER Frank Goddard

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Lois Penn

13. BIRTHPLACE OF MOTHER (State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Goddard
(Address) .....

15. Filed Feb 4 192 Ruth Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ one hour on 191 , to Feb 2nd (night) 1920 that I last saw him alive on Feb. 2nd (night) 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Influenza (Complicated and results standing)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dan S. Rumbo M. D.

19 ..... (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parma Ida	Feb 4 1920
20. UNDERTAKER	**ADDRESS**
Peerkam Cone Co	Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

3

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28956

Registered No. 1

1. PLACE OF DEATH.

County of Canyon

City of Parma

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2507

(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lewis Emory Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	M

6. DATE OF BIRTH: March 2 1883 (Month) (Day) (Year)

7. AGE: 36 yrs. 11 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: J Boyd H Green

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Melissa A Bowden

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E W Green

(Address) Boise Ida

15.

Filed Feb 10 1920 Lulu Nalder Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 8 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 191 , to Feb 8 1920 that I last saw him alive on Feb 8 1920 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Influenza & Pneumonia

(Duration) yrs. mos. 10 ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. 10 ds.

(Signed) W M Mitchell M. D.

2/9 1920 (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Parma — DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER: Peckham Car Co — ADDRESS: Parma

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

(No. ....., ... St.)

File No. 28957

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherine Hammond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) 15th (Day) 1896 (Year)

7. AGE: 23 Yrs. 6 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York City

10. NAME OF FATHER: Thomas Mullane

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. E. Laughlin

(Address) Caldwell Idaho

15. Filed 3-12-1920

John A. Mieyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/4 1920 to 3/10 1920, that I last saw her alive on 3/4 1920 and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(Duration) Not known Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) [illegible] M. D.

3/12 1920 (Address) Excused Latter

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 3-12 1920

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated in every case. PHYSICIANS should state CAUSE OF DEATH in plain English, so that it may be properly classified, and should also fill out statement of OCCUPATION as required. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & STRS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

28958

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

28958

Registration District No. 3
Primary Registration District No. 2005
File No.
Registered No. 46

1. PLACE OF DEATH.
County of Canyon
City of Middleton (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Lou Faber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: M (Write the word)

6. DATE OF BIRTH: March 3 1881 (Month) (Day) (Year)

7. AGE: 39 Yrs. — Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Bryson Walden

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Susan King

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm. Faber
(Address) Middleton Ida

15. Filed Mar 10 1920 John S. Mayes Local Registrar

BYMS - YORK CO., PTRS. & RORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 8 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 11 — 1919, to March 8 1920, that I last saw her alive on March 8 — 1920, and that death occured on the date stated above, at 7, 8 M.

The CAUSE OF DEATH* was as follows:
Menapause Insanity

(Duration) Yrs. 5 mos. 27 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Hamer M. D.
3-10 1920 (Address) Middleton Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Middleton Cem.	3-10 1920
20. UNDERTAKER	ADDRESS
J. Peckham	Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 26959

Registered No. 44

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of Star (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia C. Teyerly.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH. June (Month) 12 (Day) 1879 (Year)

7. AGE: 40 Yrs. 8 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER O. M. Stoffle.

11. BIRTHPLACE OF FATHER (State or Country) Missouri.

12. MAIDEN NAME OF MOTHER Mary Martin

13. BIRTHPLACE OF MOTHER (State or Country) Don't know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. A. Teyerly.

(Address) Caldwell Idaho Rt. #1

15.

Filed 3-6-1920

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 6 1920, to Mar. 6 1920, that I last saw her alive on — 1920, and that death occured on the date stated above, at 12-20 A.M.

The CAUSE OF DEATH* was as follows:

Suicide with Strychnine

(Duration) ..... Yrs. ..... mos. 1/2 hour ds.

Contributory (Secondary) —

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Hauser M. D.

19..... (Address) Middleton Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Cem. DATE OF BURIAL: 3-7 1920

20. UNDERTAKER: C. V. Beckham ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 28960
Registered No. 45

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stella Jane Watts
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July 26 1918 (Month) (Day) (Year)

7. AGE: 1 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Ruth Young

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert L. Watts
(Address) Caldwell

15. Filed 3-9-1920 John L. Meyer. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 7 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1920 to March 7 1920 that I last saw h[illegible] alive on March 7 1920 and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:
Infantile Cerebral Paralysis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Carr M. D.
3/8 1920 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: MAR 9 1920

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28961

Registered No. 42

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No 3

Primary Registration District No 2045

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clark H Travis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Oct (Month) 13 (Day) 1884 (Year)

7. AGE: 35 Yrs. 4 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Rancher

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas.

10. NAME OF FATHER Calvin Travis

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H R Travis

(Address) Caldwell Idaho

15. Filed 3-5- 1920 John F Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Feb 29 1920, that I last saw him alive on Feb 29 1920 and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Bales M. D.

3-2 1920 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 3-5- 1920

20. UNDERTAKER: O Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28962

Registered No. 41

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

City of Middleton, (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ora Ernest Moberly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 5 (Day) 1919 (Year)

7. AGE: ... Yrs. 9 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER O. C. Moberly

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Muriel Hadsell

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. C. Moberly

(Address) Caldwell, #10

15. Filed 3-1- 1920 John L. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1920, to Feb 28 1920, that I last saw her alive on Feb 26 1920, and that death occured on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac

..... (Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Bronchopneumonia

..... (Duration ..... yrs. ..... mos. 21 ds.

(Signed) M. Guy M. D.

3/1 1920 (Address) Caldwell Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton Cem — DATE OF BURIAL: 3-1 1920

20. UNDERTAKER: C. W. Beckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 28963
Registered No. 40

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nathaniel Clayton Croghan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Oct. (Month) 20 (Day) 1870 (Year)

7. AGE: 49 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Geo. Croghan

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Christina Myres

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. A. Laws
(Address) Caldwell #6

15. Filed 2-27-1920 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1920, to Feb. 25 1920, that I last saw h. alive on Feb. 25 1920, and that death occured on the date stated above, at 5-30a.m.

The CAUSE OF DEATH* was as follows:
Acidosis following Influenzal Septicemia, with general Hepatitis.
(Duration) — Yrs. — mos. 3 ds.
Contributory (Secondary) Influenza
(Duration — yrs. — mos. 10 ds.
(Signed) R. G. Young M. D.
Feb 27 1920 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 2-28-1920

20. UNDERTAKER: C. V. Peckham ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 28964
Registered No. 39

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph G. Grubham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Oct. (Month) 21 (Day) 1847 (Year)

7. AGE: 72 Yrs. 4 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Geo. Grubham

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. L. C. Downs
(Address) Caldwell Ida.

15. Filed 2-26- 1920 John S. Meyers. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1920, to Feb 25 1920, that I last saw him alive on Feb 26 191..., and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Interval Acterma.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
Feb. 19 27 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	Feb 26 1920
20. UNDERTAKER	ADDRESS
C. Peckham	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ....., ... St.)

File No. 28965
Registered No. 38

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olof Delane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH.
Aug (Month) 29 (Day) 1856 (Year)

7. AGE
63 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER Nils Delane

11. BIRTHPLACE OF FATHER
(State or Country) Sweden

12. MAIDEN NAME OF MOTHER Kate Olsen

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. Anderson
(Address) Caldwell, Ida.

15.
Filed 2-25- 1920
John V. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at about 8-30 A.M.,
The CAUSE OF DEATH* was as follows:
Fell dead on duty.
Fell on streets six months previous last revised.
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration) .....yrs.....mos.....ds
(Signed) C. A. Beckham Coroner
2-25 1920 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 2-25 1920

20. UNDERTAKER: C. A. Beckham ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 28966
Registered No. 37

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Billie Louise Jessee
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	white	Single (Write the word.)

6. DATE OF BIRTH: March (Month) 21 (Day) 1916 (Year)

7. AGE: 3 Yrs. 10 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Wm H. Jessee

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Nellie M. Rice

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Jessee
(Address) Caldwell Ida

15. Filed 2-20- 1920 John L. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25 1919, to Feb 19 1920, that I last saw her alive on Feb 19 1920, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Acidosis

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Bronchopneumonia
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. A. Gee M. D.
2/20 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28967

Registered No. 36

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mable Josephine Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 16 (Day) 1916 (Year)

7. AGE: 3 Yrs. 10 Mos. 2 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Montana

10. NAME OF FATHER Wallace Clark.

11. BIRTHPLACE OF FATHER (State or Country) Virginia.

12. MAIDEN NAME OF MOTHER Mary Hagy.

13. BIRTHPLACE OF MOTHER (State or Country) Virginia.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wallace Clark
(Address) Caldwell, #3

15. Filed 2-19-1920 John V. Mayes Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920, to Feb 18 1920, that I last saw h[illegible] alive on Feb 17 1920, and that death occured on the date stated above, at 1-30 P.M.

The CAUSE OF DEATH* was as follows:
Ruptured Appendix

.....(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Flu

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Forsyth M. D.

2/18 1920 (Address) Crowcroft Flu

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Abingdon Va. Bethel — DATE OF BURIAL: .....191....

20. UNDERTAKER: C. D. Peckham — ADDRESS: Caldwell, Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28968
Registered No. 63

1. PLACE OF DEATH.

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

County of Canyon
City of Middleton

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nancy C Payne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan. (Month) 17 (Day) 1840 (Year)

7. AGE: 80 Yrs. 0 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. L. Payne
(Address) Middleton Ida

15. Filed 2-15- 1920 — J. H. Meyers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febiy 1st 1920, to Febiy 14th 1920, that I last saw her alive on Febiy 13th 1920, and that death occured on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

"Flue"

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary): Old Age

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Hamer M. D.

2-14 1920 (Address) Middleton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetary Star, Ida — DATE OF BURIAL: 2-15 1920

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2003
File No. 28965
Registered No. 34

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. County Poor Farm St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Sitten

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1861 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Canyon County Patient
(b) General nature of industry, business or establishment in which employed (or employer): ●

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Sitten

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 2-16- 1920 — John S. Meyers, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 14 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1919, to Feb 14 1920, that I last saw h.[illegible] alive on Feb 13 1920, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Nephritis - Chronic
●
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W D Forrey M. D.
Feb 16, 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Feb 16 1920

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 28970
Registered No. 31

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Ann M Sack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct (Month) 14 (Day) 1857 (Year)

7. AGE: 62 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: Henry O. Carter

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Nancy Harmon

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. Sack
(Address) Nampa Ida.

15. Filed 2-13-1920 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 2-a. M.

The CAUSE OF DEATH* was as follows:
Complaint nurse pain about heart. Died about twenty minutes after.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Flue
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Peckham Coroner
2-12 1920 (Address) Caldwell, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rosedell Cem	2-14 1920
20. UNDERTAKER	ADDRESS
J. L. Peckham	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, and should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28971

Registered No. 30

1. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 2005

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lester Leedy.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Aug (Month) 4 (Day) 1901 (Year)

7. AGE: 18 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: J. W. Leedy.

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Sallie A Burford

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sallie A Leedy

(Address) Lockwood Missouri

15. Filed 2-13-1920 John S. Meyer Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4- 1920, to Feb. 10- 1920, that I last saw him alive on Feb. 10- 1920 and that death occured on the date stated above, at 6:55 A.M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumania-

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) influenza-

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) John S. Meyer M. D.

2/13 1920 (Address) Caldwell - Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lockwood Missouri. DATE OF BURIAL ..... 191...

20. UNDERTAKER: C. V. Peckham ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2005

File No. 28972

City of Caldwell

(No. ....., ... St.)

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olga Judd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April 19 1889
(Month) (Day) (Year)

7. AGE: 30 Yrs. 9 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER O. A. Sherbury

11. BIRTHPLACE OF FATHER (State or Country) Norway.

12. MAIDEN NAME OF MOTHER Dorit Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Goddard Judd
(Address) Caldwell, Idaho

15. Filed 2-12- 1920 John V. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. Feb 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2 1920, to Feb. 8 1920, that I last saw h[illegible] alive on Feb. 8 1920, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Influenza & Pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. M. Kelley M. D.

2-12 1920 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill Cem — DATE OF BURIAL: 2-12-1920

20. UNDERTAKER: C. Beckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Cole

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28973

Registered No. 28

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of Caldwell. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Hinshaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
male	white	Married

6. DATE OF BIRTH. June (Month) 14 (Day) 1881 (Year)

7. AGE 38 Yrs. 7 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa.

10. NAME OF FATHER Ezra W. Hinshaw

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Elvira Griffin

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ralph H. Burnside
(Address) 1725 Yasco Bldg - Portland Ore

15. Filed 2-20- 1920 Jobe Dwyer Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 8 (Day) 1920 (Year)
Feb.

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920 to Feb 8 1920 that I last saw h.. alive on Feb 7 1920 and that death occured on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

1 Pneumonia

..... (Duration) Yrs. ..... mos. 21 ds.

Contributory (Secondary) Influenza

..... (Duration ..... yrs. ..... mos. 8 ds.

(Signed) H.H. Cole M. D.

2/10. 1920 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Oskaloosa Iowa — DATE OF BURIAL .....191.....

20. UNDERTAKER Peckham Furn Co. — ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

File No. 28974

County of Caribou

City of ..... (No. ....., ... St.)

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dean Ellis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 1, (Day) 1913 (Year)

7. AGE: 1 Yrs. 3 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: school
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joe Ellis

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ellie Riddell

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Elsie Ellis
(Address) Mc Cammon, Idaho

15. Filed 2 – 20 1920 Ellis Kasey Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 19 1920, to Feby 19 1920, that I last saw him alive on Feby 19 1920, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Pneumonia

(Duration ..... yrs. ..... mos. 1 ds.

(Signed) Russell Tyrrell M. D.

2/20 1920 (Address) Soda Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: E. D. Whitman Cabin — DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: E. D. Whitman — ADDRESS: Soda Springs Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28975

Registered No. 5

1. PLACE OF DEATH.

County of Bonneville

City of Soda Springs

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey Wm. Graham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. Jan. (Month) 5 (Day) 1896 (Year)

7. AGE: 24 Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Rancher

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Geo. W. Graham

11. BIRTHPLACE OF FATHER (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Matilda Severson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Graham

(Address) Wayan, Idaho

15. Filed Feb. 11, 1920 Eric Kurt Lee Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h— alive on — 191...,

and that death occured on the date stated above, at 10¼ M.

The CAUSE OF DEATH* was as follows:

Killed by Gunshot wound, inflicted in Altercation

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) — a woman

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Eric Kaeser M. D.

19..... (Address) Soda Springs Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Soda Springs, Ida — DATE OF BURIAL: Feb 12 1920

20. UNDERTAKER: Ed Wilkinson — ADDRESS: Soda Springs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28976

Registered No. 4

1. PLACE OF DEATH.

County of Bonneville

City of Soda Springs

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11

Primary Registration District No. 2048

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leo Gillett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED~~, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 27 (Day) 1918 ~~1898~~ (Year)

7. AGE: 2 Yrs. — Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) none

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Earl Gillett

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Harriet Eyhert

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Earl Gillett

(Address) Soda Springs Idaho

15. Filed Feb 10, 1920 Ellis Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,

that I last saw h— alive on ..... 191—,

and that death occured on the date stated above, at 4 Pm M.

The CAUSE OF DEATH* was as follows:

From the discomfiture given by the Father, I believe he died from Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) none

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ellis Kinney M. D.

Feb 19 20 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grace

DATE OF BURIAL: Feb 11 1920

20. UNDERTAKER: Ed Whitlin

ADDRESS: Grace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28977
Registered No. 402

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Condit

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 24 (Day) 1876 (Year)

7. AGE: 43 Yrs. 3 Mos. 15 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Hiram Rice

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Oline Smith

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leon Condit
(Address) Burley Ida.

15. Filed Feb 9 1920
Dr. J. C. Pattison
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1919 to Feb 8 1920
that I last saw her alive on Feb 8 1920
and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Tuberculosis
About
(Duration) 15 Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) [illegible] M. D.
2-9-1920 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery — DATE OF BURIAL: 2/9 1920

20. UNDERTAKER: Kinnatt — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Burley

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28978
Registered No. 403
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

2. FULL NAME Rodney John Kayle

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 30 (Day) 1907 (Year)

7. AGE: 12 Yrs. 10 Mos. 9 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Spanish Fork Ut

10. NAME OF FATHER Silas A Kayle

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Hannah Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C R Boynton
(Address) Burley

15. Filed Feb. 9 1920 Wm. J. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6 1920 to ..... 191..
that I last saw him alive on Feb. 6 1920.
and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

.....(Duration) ..... Yrs..... mos..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos..... ds.

(Signed) R. C. Barta M. D.
2/23 1920. (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pleasant View Cemetery — DATE OF BURIAL 2/9 1920.

20. UNDERTAKER Rummel — ADDRESS Burley

FORM V. S. No. 5-12 M. 6-15-17.

Cutler

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28979

Registered No. 404

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 2196

(No. ....., ... St.)

2. FULL NAME Marva Ray Deuel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word) Single

6. DATE OF BIRTH. Jan (Month) 9 (Day) 1920. (Year)

7. AGE 0 Yrs. 1 Mos. 0 ds.

IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L E Deuel

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Elena Barr

13. BIRTHPLACE OF MOTHER (State or Country) N.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. L E Deuel

(Address) .....

15. Filed Feb. 10. 1920. Dr. J. C Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby. 7. 1920 to Feby. 9. 1920 that I last saw her alive on Feby. 9. 1920 and that death occurred on the date stated above, at 3. P. M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Spanish Influenza

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) F. H. Cutler M. D.

2-10. 1920. (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery — **DATE OF BURIAL** 2. 11. 1920

20. UNDERTAKER Rinehart — **ADDRESS** Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

Patterson

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28980
Registered No. 765

Registration District No. 117
Primary Registration District No. 2194

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvin O. Bodily

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): D

6. DATE OF BIRTH. Dec (Month) 7 (Day) 1854 (Year)

7. AGE 75 Yrs. 2 Mos. 3 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W E Bodily

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Harriet A Olivenson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M W Bodily
(Address) Burley R 3

15. Filed 2-11-20 191.... Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8th 1920 to Feb 10th 1920
that I last saw h. alive on Feb 10 1920.
and that death occurred on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos. several ds.
Contributory (Secondary) Pneumonia
(Duration) ..... Yrs. ..... mos. 3 ds.
(Signed) J. C. Patterson M. D.
2-11 1920 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pella cemetery — DATE OF BURIAL: 2/14 1920

20. UNDERTAKER: Burratt — ADDRESS: Burley

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 28981
Registered No. 406

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfa Etta Ehrlingberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. March 30 1881 (Month) (Day) (Year)
7. AGE: 38 Yrs. 10 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Arkansas
10. NAME OF FATHER: Charles Hubby
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Sarah Burton
13. BIRTHPLACE OF MOTHER (State or Country): Tennessee
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert N. Ehrlingberg
(Address) Near Burley Ida
15. Filed 2-12-20 191.... H. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 2 1920, to Feb. 11 1920, that I last saw h.. alive on Feb. 10 1920 and that death occured on the date stated above, at 7 a. M.
The CAUSE OF DEATH* was as follows:
Influenza Pneumonia
with Pulmonary abscess.
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. V. Barts M. D.
2/19 1920 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death. 6 yrs. ..... mos. ..... days. In the State. 6 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Oklahoma

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery
DATE OF BURIAL: Feb 12 1920
20. UNDERTAKER: L B Halloglay
ADDRESS: Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BANNS

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

Patterson

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

File No. 28982
Registered No. 407
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Raymond N. Allen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
M	White	S

6. DATE OF BIRTH. Nov (Month) 21 (Day) 1918 (Year)

7. AGE 1 Yrs. 2 Mos. 24 ds. | IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Willis Allen

11. BIRTHPLACE OF FATHER (State or Country) Work

12. MAIDEN NAME OF MOTHER Lenora Austin

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nelson Allen
(Address) Burley

15. Filed 2-14-20 191.... Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920 to Feb 14 1920
that I last saw him alive on Feb 14 1920
and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
2-14-1920 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery — DATE OF BURIAL 7-15-1920

20. UNDERTAKER Howard — ADDRESS Burley

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 117
Primary Registration District No. 2196
(No. 1154 No Caverland St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28983
Registered No. 428

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Pratt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Jan (Month) 1 (Day) 1844 (Year)

7. AGE: 76 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: Thomas Smart

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William O Pratt
(Address) Burley Ida

15.
Filed Feb. 19 1920 Dr. J. C Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1920, to Feb 1 1920, that I last saw h.. alive on Feb. 1 1920, and that death occured on the date stated above, at 11.15 A. M.

The CAUSE OF DEATH* was as follows:
Apoplexy
Paralysis

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) J. C. Patterson M. D.
2-18 1920 (Address) Burley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Ida — DATE OF BURIAL: Feb 20 1920

20. UNDERTAKER: J B Kellogg — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28984

Registered No. 469

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lila Boyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 6 (Day) 1919 (Year)

7. AGE: Yrs. 3 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida

10. NAME OF FATHER: John S. Boyle

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah

12. MAIDEN NAME OF MOTHER: Lila McCullough

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John S. Boyle

(Address) Burley Ida

15.

Filed Feb. 20 1920

Dr. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920, to Feb 15 1920, that I last saw her alive on Feb 18 1920, and that death occured on the date stated above, at 6:30 P M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Bronchial Pneumonia

(Duration ..... yrs. ..... mos. 8 ds.

(Signed) J. C. Patterson M. D.

2-17 1920 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery | DATE OF BURIAL: Feb 20 1920

20. UNDERTAKER: L. B. Gallogly | ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Cullen

FORM V. S. No. 5-12 M. 6-15-17.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 20985
Registered No. 410

CERTIFICATE OF DEATH

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Everett Pomeroy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH. May 13 1919
(Month) (Day) (Year)

7. AGE ..... Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wash

10. NAME OF FATHER George Pomeroy

11. BIRTHPLACE OF FATHER (State or Country) Miss

12. MAIDEN NAME OF MOTHER Mary Malone

13. BIRTHPLACE OF MOTHER (State or Country) Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Pomeroy
(Address) Burley Rt

15. Filed Feb 21 1920 Dr. J. C. Portman
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 20 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-~~18~~-20 1920 to 2-20 1920 that I last saw him alive on 2-20 1920 and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:

Hooping Cough

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) F. H. Cutler M. D.

2-20 1920 (Address) F. Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Burley Cemetery — **DATE OF BURIAL** 2/21 1920

20. UNDERTAKER Rinehart — **ADDRESS** Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

Cooper

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28986
Registered No. 411

CERTIFICATE OF DEATH

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Owyhee
City of Dunlay

2. FULL NAME Robert Anthony Yonney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. May (Month) 4 (Day) 1892 (Year)

7. AGE: 27 Yrs. 11 Mos. 0 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer Worker
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Eaves
(Address) Dunlay Ida

15. Filed Feb. 5 1920 Wm J. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Feb — 4 — 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-1- 1920 to Feb-4- 1920
that I last saw her alive on Feb-4- 1920
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) — Yrs. — mos. -4- ds.
Contributory (Secondary) Influenza
(Duration) — Yrs. — mos. — ds.
(Signed) W. A. Cooper M. D.
19.... (Address) Dunlay Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dunlay Ida — DATE OF BURIAL: 2/7 1920

20. UNDERTAKER: Howard — ADDRESS: Dunlay Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Cassia

City of Burley

Registration District No. 117

Primary Registration District No. 2196

(No. ....., ... St.)

File No. 28987

Registered No. 412

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Etta Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. May (Month) 2 (Day) 1888 (Year)

7. AGE: 31 Yrs. 9 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nephi Utah

10. NAME OF FATHER: Samuel Tolley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Jane Pipton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Milton L. Scott

(Address) Burley Ida

15. Filed Feb. 6 1920 D. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1920 to Feb 4 1920, that I last saw her alive on Feb 4 1920, and that death occured on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Influenza Sp.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. K. Cutler M. D.

19..... (Address) Burley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. ..... mos. ..... days. In the State 5 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Foremost Canada

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery | DATE OF BURIAL: Feb 6 1920

20. UNDERTAKER: L. B. Gallogly | ADDRESS: Burley Ida

Dr Cutler

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24858

Patterson

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28988
Registered No. 401

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 2196

(No. 8, ... St.)

2. FULL NAME Saunders Edquist

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Dec (Month) 12 (Day) 1865 (Year)

7. AGE 54 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER John Edquist

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Mary Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J W Edquist

(Address) Burley

15. Filed 2-6-20 1920

Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920 to Feb 5 1920 that I last saw h~~im~~ alive on Feb 5 1920 and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Influenza

.....(Duration) ..... Yrs. ..... mos. ~~several~~ ds.

Contributory (Secondary) Pneumonia

.....(Duration) ..... Yrs. ..... mos. 2 ds.

(Signed) J. C. Patterson M. D.

2-6 1920. (Address) Burley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Meadow Creek Cemetery

DATE OF BURIAL 2/7 1920

20. UNDERTAKER Rummatt

ADDRESS Burley

FORM V. S. No. 5-12 M. 6-15-17.

Cutler

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28989
Registered No. 760

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

2. FULL NAME Ortentia Ellen Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. Jan (Month) 7 (Day) 1895 (Year)

7. AGE: 25 Yrs. 0 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: E Croft

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah B Jolley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah B Croft
(Address) Burley Ida

15. Filed Feb. 4 1920. Dr. J. C. Pettinger Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920 to Feb 3 1920 that I last saw h[illegible] alive on Feb 3 1920 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

B Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Inf. Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) F K Cutler M. D.

2-4-1920. (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cemetery — DATE OF BURIAL: 3 Feb 1920

20. UNDERTAKER: Nuewatt — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Patterson

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28990
Registered No. 399
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 117
Primary Registration District No. 2196
(No. ...., ... St.)

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Bowcutt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. July (Month) 10 (Day) 1855 (Year)

7. AGE: 65 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Eng

10. NAME OF FATHER: John Wilson

11. BIRTHPLACE OF FATHER (State or Country): Eng

12. MAIDEN NAME OF MOTHER: Elizabeth Hartley

13. BIRTHPLACE OF MOTHER (State or Country): Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Bowcutt
(Address) Burley

15. Filed 2-28 1920 J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1920 to Feb 20 1920 that I last saw h.. alive on Feb 27 1920. and that death occurred on the date stated above, at 7 a.m.

The CAUSE OF DEATH* was as follows:
Intermittent of Bones
.....
.....
.....(Duration) several Yrs..... mos..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos..... ds.

(Signed) J. C. Patterson M. D.
2-25 1920 (Address) Burley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Franklin Ida — DATE OF BURIAL: 3/1 1920

20. UNDERTAKER: Rowoodth — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 28991
Registered No. 378

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas Howard Lashbrook

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 6 (Day) 1845 (Year)

7. AGE: 74 Yrs. 10 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Chas Lashbrook

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Howards

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs C St Lashbrook
(Address) Burley

15. Filed Feb. 14 1920 Wm J. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 13 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 19 1920, to Feb. 13 1920, that I last saw him alive on Feb. 13 1920, and that death occured on the date stated above, at 11.45 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ..... Yrs. ..... mos. 25 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Patterson M. D.
2-14 1920 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah
DATE OF BURIAL: March 191

20. UNDERTAKER: Ramsdell
ADDRESS: Burley

FORM V. S. No. 5-12 M. 6-15-17.

Cooper

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28992

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

Registered No. 376

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH,
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Milton Pulley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 27 (Day) 1890 (Year)

7. AGE: 29 Yrs. 9 Mos. 11 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James H Pulley

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Alice M Thornton

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jas H Pulley
(Address): Burley Ida

15. Filed Feb 10 1920
Wm J Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920 to Feb 7 1920
that I last saw h.. alive on Feb 7th 1920
and that death occurred on the date stated above, at 3.30 M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) — Yrs. — mos. 4 ds.
Contributory (Secondary) Influenza
(Duration) — Yrs. — mos. 10 ds.

(Signed) C H Cooper M. D.
2-10-1920. (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: American Falls Cem. DATE OF BURIAL: 2/12 1920

20. UNDERTAKER: Rowatt ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ..... St.)

File No. 28993
Registered No. 375

1. PLACE OF DEATH.
County of Cassia
City of Burley.
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Harlan Clark.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July 18 1919.
(Month) (Day) (Year)

7. AGE: ....Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley.

10. NAME OF FATHER: James H. Clark.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ella Hills.

13. BIRTHPLACE OF MOTHER (State or Country): Provo Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Harlan Clark.
(Address) Burley Idaho

15. Filed Feb 6 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 5 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Feb 5 1920, that I last saw h[illegible] alive on Feb 5 1920, and that death occured on the date stated above, at 7a.m. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) [illegible] M. D.

Feb 6 1920 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Provo Utah. DATE OF BURIAL: Jan Interval

20. UNDERTAKER: L. S. Galloway. ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ..... St.)
Registration District No. 117
Primary Registration District No. 2196
File No. 28994
Registered No. 374
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dean Fred Warnick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. May (Month) 13 (Day) 1918 (Year)
7. AGE: 1 Yrs. 8 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Pleasant Grove Ut
10. NAME OF FATHER: Willard A Warnick
11. BIRTHPLACE OF FATHER (State or Country): Pleasant Grove Utah
12. MAIDEN NAME OF MOTHER: Agnes Christianson
13. BIRTHPLACE OF MOTHER (State or Country): Provo Ut
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Willard A Warnick
(Address): Burley Ida
15.
Filed 2-5-20 191 R. J. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1920, to Feb 4 1920, that I last saw h[illegible] alive on Feb 4 1920, and that death occured on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. V. Beaty M. D.
2-5 1920 (Address) Burley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 5 mos. ..... days. In the State ..... yrs. 5 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Pleasant Grove Ut

19. PLACE OF BURIAL OR REMOVAL: Pleasant Grove Ut | DATE OF BURIAL: 2nd
20. UNDERTAKER: L. B. Galloglay | ADDRESS: Burley Ida

R 2-5-20

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28995

Registered No. 373

1. PLACE OF DEATH.

County of Cassia

City of Declo

(No. ....., ... St.)

Registration District No. 117

Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Leon Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 16 (Day) 1893 (Year)

7. AGE 26 Yrs. 11 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Newton Utah

10. NAME OF FATHER: Amos R. E. Clark

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Fedilia Haskell

13. BIRTHPLACE OF MOTHER (State or Country): Payson Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Haskell

(Address) Fielding Utah

15. Filed Feb 2 1920

Dr. J. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1920, to Feb 1 1920, that I last saw him alive on ..... 191..., and that death occured on the date stated above, at 11:45 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Simmons M. D.

2-2-1920 (Address) Rupert Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 6 mos. ..... days In the State ..... yrs. 6 mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Newton Utah

19. PLACE OF BURIAL OR REMOVAL: Newton Utah — DATE OF BURIAL: Feb 4 1920

20. UNDERTAKER: L. B. Halloglay — ADDRESS: Burley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

Patterson

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

File No. 28996
Registered No. 377
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Ann Walters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feby (Month) 21 (Day) 1886 (Year)

7. AGE: 33 Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ~
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Salt Lake City Utah

10. NAME OF FATHER Henry B. Walters

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Caroline Francis

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Wilson
(Address) Burley R

15. Filed Feb 5 1920
Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feby (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1919 to Feb 7 1920
that I last saw her alive on Feb 1st 1920
and that death occurred on the date stated above, at 10 a.m. M.
The CAUSE OF DEATH* was as follows:
Epilepsy
(Duration) 20 Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) J. C. Patterson M. D.
2-9 1920 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Salt Lake City Ut DATE OF BURIAL Feb 10 1920

20. UNDERTAKER Newvath ADDRESS Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2306
Registered No. 378

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur E Chambers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 31 (Day) 1882 (Year)

7. AGE: 37 Yrs. 7 Mos. 28 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Frank E Chambers

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Sarah Brower

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W. L. Magginnis
(Address): Burley Ida

15. Filed Feb 4 1920. Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920 to Jan 28 1920
that I last saw him alive on Jan 25 1920
and that death occurred on the date stated above, at 10a. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) .... Yrs. .... mos. 4 ds.
Contributory (Secondary) Influenza
(Duration) .... Yrs. .... mos. 3 ds.

(Signed) H. E. Smith M. D.
1/28 1920 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City
DATE OF BURIAL: 2/ 1920

20. UNDERTAKER: Kinnear
ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

Smith

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 23006
Registered No. 397

Registration District No. 117
Primary Registration District No. 2196

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Schneider

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 20 (Day) 1920 (Year)

7. AGE ——Yrs. ——Mos. ——ds.
IF LESS than 1 day how many 3 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Nels Schneider

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Minnie Moore

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nels Schneider
(Address) Burley

15.
Filed Jan 21 1920 Dr J C Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to Jan 20 1920
that I last saw h.... alive on Jan 20 1920
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... Yrs..... mos..... ds.

Contributory (Secondary)

(Duration) ..... Yrs..... mos..... ds.

(Signed) G H Smith M. D.
1/22 1920 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery — DATE OF BURIAL 1/21 1920

20. UNDERTAKER Riverside — ADDRESS Burley

FORM V. S. No. 5-12 M. 6-15-17.

Patterson

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2905
Registered No. 376

Registration District No. 117
Primary Registration District No. 2196

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert F. Dyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 12 (Day) 1843 (Year)

7. AGE: 76 Yrs. 8 Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Johnathan Dyer

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Nancy Boley

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Scott
(Address) Burley R.F.

15. Filed Jan 20 1920
Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1919 to Jan 18 1920.
that I last saw h~~im~~ alive on Jan 16 1920
and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Senility

(Duration) ..... Yrs. ~~one~~ mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
2-19 1920 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days, In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery — DATE OF BURIAL: Jan 20 1920

20. UNDERTAKER: Kinnatt — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 117

Primary Registration District No. 2196

(No. ....., ... St.)

Along

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29008
Registered No. 3 75
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leon Kinnard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov 27 1914 (Month) (Day) (Year)

7. AGE: 5 Yrs. 1 Mos. 23 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Charles Kinnard

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Florence Sargent

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Kinnard
(Address) Burley R.F.

15.
Filed Jan 16 1920 Dr. J. Bathman Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 14 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 to Oct 28 19 17
that I last saw him alive on Oct 28 19 17
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Myocarditis
(Duration) Don't know Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) R. J. Story M. D.
Jan 19 1920 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery — DATE OF BURIAL 1/15 1920

20. UNDERTAKER Riewatt — ADDRESS Burley Ida

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 117

Primary Registration District No. 2196

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29009

Registered No. 3994

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Donald Condit

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Oct (Month) 28 (Day) 1918 (Year)

7. AGE: 1 Yrs. 2 Mos. 14 ds.

IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. D. Condit

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Edna Rice

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. D. Condit

(Address) Burley Ida

15.

Filed Jan 12 1920

Dr. J. E. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1920 to Jan 10 1920 that I last saw h.... alive on Jan 10 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....

.....

.....(Duration) ..... Yrs..... mos. 3 ds.

Contributory (Secondary) None

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) R. J. Storey M. D.

.....19.... (Address) Burley, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery — DATE OF BURIAL Jan 17 1920

20. UNDERTAKER Ruerwatt — ADDRESS Burley Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29019
Registered No. 373

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Keith Obray

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH. Dec (Month) 7 (Day) 1919 (Year)

7. AGE: ..... Yrs. ..... Mos. 30 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Burley Ida

10. NAME OF FATHER David Obray

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Nora Miles

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Obray
(Address) Burley

15.
Filed Jan 3 1920 Dr. J. C. Pattison
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 2 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1919 to Jan 2 1920
that I last saw h. in alive on Jan 2 1920
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia
.....
.....
.....(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory .....
(Secondary)
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
1/2 1920 (Address) ..... Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery — DATE OF BURIAL 1/3 1920

20. UNDERTAKER Rideout — ADDRESS Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 29012
Registered No. 391

1. PLACE OF DEATH.
County of Cassia
City of Vieir Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Espirion Castro

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Unknown (Month) (Day) (Year)

7. AGE about 75 Yrs. ..... Mos. ..... Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Patricio Rocha
(Address) Vieir Ida

15. Filed Jan 28 1920 Dr. J. C Bottum
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to Jan 2 1920, that I last saw him alive on Jan 2 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of Liver
with Ascites

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Smith M. D.
1/5 1920 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days
In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery
DATE OF BURIAL: Jan 30 1920

20. UNDERTAKER: L B Gallogly
ADDRESS: Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Smith

SVMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 2896

(No. No Overland 2nd St.) City Limits

File No. 29013

Registered No. 990

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Guymon Garner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 6 (Day) 1913 (Year)

7. AGE: 6 Yrs. 6 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Huntsville Utah

10. NAME OF FATHER: Leslie Garner

11. BIRTHPLACE OF FATHER (State or Country): Huntsville Utah

12. MAIDEN NAME OF MOTHER: Cora Bateman

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leslie Garner

(Address) Burley Ida

15. Filed Jan. 30 1920 W. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 24 1920, to Jan 29 1920, that I last saw him alive on Jan 29 1920, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F K Cutler M. D.

19..... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery

DATE OF BURIAL: Jan 30 1920

20. UNDERTAKER: L B Gallogly

ADDRESS: Burley

Dr Cutler

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29014

Registered No. 389

1. PLACE OF DEATH.

County of Cassia

City of Burley Ida

(No. 952 St. No Overland Ave)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 2196

2. FULL NAME Laura Bell Driggs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 6 (Day) 1919 (Year)

7. AGE ..... Yrs. 2 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Burley Ida

10. NAME OF FATHER: Samuel Driggs

11. BIRTHPLACE OF FATHER (State or Country): Kaysville Utah

12. MAIDEN NAME OF MOTHER: Lottie Olivit

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Samuel Driggs

(Address) Burley Ida

15. Filed Jan 28 1920 Roger Patten Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Jan 27 1920, that I last saw he alive on Jan 27 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Malnutrition

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F H Cutler M. D.

1920 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery

DATE OF BURIAL: Jan 28 1920

20. UNDERTAKER: L. B. Talbot

ADDRESS: Burley Ida

Dr Cutler

1

SYMS - YORK CO., PTRS. & BOKS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

File No. 29015

Registered No. 988

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Burley

(No. 360 Oriental Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillian Luella Beutler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FE

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 24 (Day) 1892 (Year)

7. AGE: 27 Yrs. 1 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Falls Ida

10. NAME OF FATHER: Robert B. Nelson

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Anna Heath

13. BIRTHPLACE OF MOTHER (State or Country): Idaho Falls Ida

14. THE ABOVE IS TRUE, TO THE BEST OF ~~MY~~ KNOWLEDGE.

(Informant) Benjamin L. Beutler

(Address) Burley Ida

15. Filed Jan 27 1920 Wm. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1920, to Jan 24 1920, that I last saw h[illegible] alive on Jan 24 1920, and that death occured on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Premature Birth.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary): Influenza.

(Duration ..... yrs. ..... mos. 5 ds.

(Signed) J. C. Patterson M. D.

1-24 1920 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. ..... mos. ..... days. In the State 27 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery

DATE OF BURIAL: Jan 25 1920

20. UNDERTAKER: L. B. Gallogly

ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

Premature

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29016

Registered No. 386

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

County of Cassia

City of Burley. (No. 130 N. Miller Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Edwards Bennett.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 1st. (Day) 1911 (Year)

7. AGE: 9 Yrs. 11 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... At Home.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER William E. Bennett.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Nellie Edwards.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Nellie E. Bennett.

(Address) Burley Ida 130 N. Miller.

15.

Filed Jan 16 1920 Dr. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 16. (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 - 1919, to Dec 20 - 1919, that I last saw him alive on Dec 20 - 1919, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory Secondary Valvular Heart Disease

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Joseph Stremler M. D.

19..... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery — DATE OF BURIAL: Jan 18 1920

20. UNDERTAKER: L. B. Yahn & Co. — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Cutler.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29017

Registered No. 887

1. PLACE OF DEATH.

County of Cassia.

City of Burley.

(No. ....., ... St.)

Registration District No. 117

Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby. Brunes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. Jan. (Month) 17 (Day) 1920. (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Burley Ida.

10. NAME OF FATHER Clyde Brunes.

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Nora Peterson.

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clyde Brunes

(Address) Burley Ida.

15. Filed Jan 18 1920 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1920, to 1-17 1920, that I last saw he was alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Cutler M. D.

19.... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Jan 18 1920

20. UNDERTAKER: L. B. Bellogh. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Stony

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

File No. 29018
Registered No. 385

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Burley.

2. FULL NAME George Schulze.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 18 (Day) 1884 (Year)

7. AGE: 35 Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Emil Schulze.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Caroline Boldman.

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Schulze.
(Address) R.F.D. # 3 Burley Ida.

15. Filed Jan 11 1920 Dr. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920, to Jan 11 1920, that I last saw him alive on Jan 11 1920, and that death occured on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

..... (Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) Influenza
..... (Duration) ..... yrs. ..... mos. 14 ds.

(Signed) R. J. Story M. D.
Jan 11 1920 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Jan. 15 1920

20. UNDERTAKER: L. B. Gallagher. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29019

Registered No. 384

1. PLACE OF DEATH.

County of Cassia.

City of Burley.

(No. R.F.D. # 2. St.)

Registration District No. 117

Primary Registration District No. 2196

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rae Smith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. (Month) 6. (Day) 1918. (Year)

7. AGE: 1 Yrs. 10 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): View Ida.

10. NAME OF FATHER: Victor Smith.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Maggie Metcalf.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Victor Smith.

(Address) R.F.D. # 2.

15.

Filed Jan. 2 1920 Dwight Porter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 1 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1919, to Jan 1 1920, that I last saw her alive on Jan 1 1920 and that death occured on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) R. J. Story M. D.

Jan. 1 1920 (Address) Burley, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: View Ida. DATE OF BURIAL: Jan. 4 1920.

20. UNDERTAKER: L. B. Gallogly. ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117

Primary Registration District No. 2196

File No. 29020

Registered No. 372

1. PLACE OF DEATH.

County of Cassia

City of Burley Ida

(No. 360 Oriental Ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Marie Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FE

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. Mar (Month) 18 (Day) 1873 (Year)

7. AGE: 46 Yrs. 10 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls Ida

10. NAME OF FATHER George T. Heath

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emery Nelson

(Address) Glendale Ariz

15.

Filed Jan 27 1920 Dr. J. C. Patterson Local Registrar

BYNS - YORK CO., PTRS. & ENGS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 19 1920, to Jan. 25 1920, that I last saw h[illegible] alive on Jan 25 1920, and that death occured on the date stated above, at 1.50 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Influenza

(Duration ..... yrs. ..... mos. 4 ds.

(Signed) J. C. Patterson M. D.

1-27 1920 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 4 yrs. ..... mos. ..... days In the State 46 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Ogden Utah

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: On Arrival

20. UNDERTAKER: L. B. Talbot — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 29021
Registered No. 371

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Lee Judd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Mar (Month) 26 (Day) 1884 (Year)

7. AGE
37 Yrs. 9 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Alabama

10. NAME OF FATHER: Joseph P. Simson

11. BIRTHPLACE OF FATHER
(State or Country) Ala

12. MAIDEN NAME OF MOTHER: Sarah West June

13. BIRTHPLACE OF MOTHER
(State or Country) Ala

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. D. Judd
(Address) Burley

15.
Filed Jan. 22 1920 Dr. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1920, to Jan 21 1920, that I last saw her alive on Jan 20 1920, and that death occured on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
— (Duration) — Yrs. — mos. ..... ds.
Contributory (Secondary) Infection
— Duration — yrs. — mos. — ds.

(Signed) Joseph Trigueros M. D.
19 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pima Ariz — DATE OF BURIAL 191

20. UNDERTAKER: Burcart — ADDRESS Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29022
Registered No. 370

1. PLACE OF DEATH.
County of Oneida.
City of Dursley.
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 117
Primary Registration District No. 2196.
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward L. Wood.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown, ... 1 .....
(Month) (Day) (Year)

7. AGE: about 45 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown.

10. NAME OF FATHER: ' '

11. BIRTHPLACE OF FATHER (State or Country): ' '

12. MAIDEN NAME OF MOTHER: ' '

13. BIRTHPLACE OF MOTHER (State or Country): ' '

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Secured by letters in Suit Case.
(Address) Miss Frances Wood, Logan Utah.

15.
Filed Jan 8 1920 W. J. Patterson
Local Registrar

SYMS - YORK CO., PTYS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 6 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Asphyxiated in Mine from Blasting Powder Gases
Accidental.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L.B. Bulloch = Coroner = M. D.
Jan 8 1920. (Address) Burbley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan Utah.
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: L.B. Bulloch.
ADDRESS: Burbley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29023

Registered No. .....

1. PLACE OF DEATH.

County of Cassia

City of Malta

(No. ....., ... St.)

Registration District No. 119

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 16 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Malta Idaho

10. NAME OF FATHER: George R Richins

11. BIRTHPLACE OF FATHER (State or Country): Grouse Creek Utah

12. MAIDEN NAME OF MOTHER: Mabey R. Warburton

13. BIRTHPLACE OF MOTHER (State or Country): Tooele Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo R. Richins

(Address) Malta Ida.

15. Filed Feb 1 1920

L. D. Sater
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to Feb 9 1920, that I last saw h[illegible] alive on Feb 9 1920, and that death occured on the date stated above, at 5:15 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia,

.....

.....

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

2/1 1920 (Signed) L. D. Sater M. D.

(Address) Malta

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 24 days. In the State.....yrs.....mos. 24 days

Where was disease contracted if not at place of death? At place of death

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Malta Cemetary — DATE OF BURIAL .....191.....

20. UNDERTAKER: None — ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 25024
Registered No. 1

1. PLACE OF DEATH
County of Clearwater
City of Weippe Ida.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H B Haywood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 15 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 5 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: H B Haywood.

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Amanda Smith

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H B Haywood
(Address) Weippe Ida.

15. Filed Jany 16 1920 J M Tandy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 16 1920 to Jany 16 1920 that I last saw h[illegible] alive on Jany 16 1920 and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:

Premature birth
(7 Months)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) J M Tandy M. D.
Jany 1920 (Address) Orofino, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weippe Ida — DATE OF BURIAL: 1/17 1920

20. UNDERTAKER: F A Shaw — ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No. 2203
File No. 29025
Registered No.

1. PLACE OF DEATH
County of Clark
City of Dubois
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecelia C Reeves

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1889 (Year)

7. AGE: 30 Yrs. 4 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher x
(b) General nature of industry, business or establishment in which employed (or employer): at Home

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Ludwig A Michaels

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Michaels
(Address) Dubois Ida

15. Filed Feb 15 1920 — C E Jones M D, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1920, to Feb 14 1920, that I last saw h.r alive on Feb 14 1920, and that death occurred on the date stated above, at 2-30 P M.

The CAUSE OF DEATH* was as follows:

Spanish Influenza

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary): Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) C E Jones M. D.

2/15 1920 (Address) Dubois Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence: Ida

19. PLACE OF BURIAL OR REMOVAL: Walla Walla, Wash. — DATE OF BURIAL: Feb 16 1920

20. UNDERTAKER: C C Dunwoody — ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29026
Registered No.

1. PLACE OF DEATH.
County of Canby
City of Emmett
(No. ....., ... St.)
Registration District No. 125
Primary Registration District No. 2203
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Bernice Driscoll

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: Jan (Month) 19 (Day) 1918 (Year)

7. AGE: 2 yrs. 1 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dubois Idaho

10. NAME OF FATHER: Wm J Driscoll

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Charlotte Miller

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W J Driscoll
(Address) Emmett Idaho

15.
Filed Feb 24 1920 C E Jones M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 24 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1920, to Feb 24 1920, that I last saw her alive on Feb 28 1920, and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) C E Jones M. D.

2/24/1920 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: Mch 1 1926

20. UNDERTAKER: None
ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 58a

Primary Registration District No. 2138

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29027
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cammas
City of Fairfield
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Baxter

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) ..... 1886 (Year)

7. AGE: 33 Yrs. 1 Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James Baxter

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florence McKay
(Address) Fairfield Idaho

15. Filed March 6 1920
I W Leuchick
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920 to Feb 5 1920
that I last saw him alive on Feb 5 1920
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia
.....
.....
.....
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Spanish influenza
(Duration) ..... Yrs. ..... mos. 4 ds.
(Signed) I W Leuchick M. D.
Feb 9 1920 (Address) Fairfield Idah

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 yrs. 1 mos. ..... days. In the State 7 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Salt Lake City Utah

19. PLACE OF BURIAL OR REMOVAL, Pleasant Grove Utah — DATE OF BURIAL 1920

20. UNDERTAKER H L McClain — ADDRESS Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29028
Registered No.

1. PLACE OF DEATH.
County of Bannock
City of Fairfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58
Primary Registration District No. 2138
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Dean Moon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Feb (Month) 4 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Fairfield, Idaho

10. NAME OF FATHER: Ruben E. Moon

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Louise Howell

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ruben E. Moon
(Address) Fairfield, Idaho

15.
Filed Mch 6 1920 L Wilcheck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1920, to Feb 4 1920 that I last saw h alive on Feb 4 1920, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Acute Myocarditis

..... (Duration) ..... yrs. ..... mos. Few second ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Wilcheck M. D.
Mch 6 1920 (Address) Fairfield, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29029
Registered No.

1. PLACE OF DEATH.
County of Canes
City of Manard
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58 4
Primary Registration District No. 2138
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ida Ethel Finch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Single

6. DATE OF BIRTH
Jan. (Month) 8 (Day) 1920 (Year)

7. AGE
..... yrs. 1 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Manard, Idaho.

10. NAME OF FATHER R. N. B. Finch

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Christina May Bair

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. N. B. Finch
(Address) Manard, Idaho

15.
Filed Mch 6 1920 I Wellencheck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920, to Feb 12 1920, that I last saw h w alive on Feb 12 1920, and that death occurred on the date stated above, at 3. A. M.

The CAUSE OF DEATH* was as follows:
Convulsions of intestinal origin

..... (Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) I Wellencheck M. D.
Mch 6 1920 (Address) Fairfield, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191..

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 29030
Registered No. 7

1. PLACE OF DEATH
County of Clearwater
City of or Town Orofino
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jack Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH ? (Month) ? (Day) ? (Year)

7. AGE dont Know Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Finland

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. McHenry
(Address) Orofino Ida

15. Filed Mch 20 1920 J. M. Faust Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 31 (Day) 1920 (Year)

17. I ~~HEREBY~~ CERTIFY, That I attended deceased from Aug 15 1914, to Jan 31 1920
that I last saw him alive on Jan 31 1920
and that death occurred on the date stated above, at 8 a M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
..... (Duration) 5 yrs. ? mos. ? ds.
(Signed) J. Olive Jr. Stivers M. D.
2/1 1920 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. 5 mos. 16 days. In the State ? yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Lenore Nez Perce Co

19. PLACE OF BURIAL OR REMOVAL: N. P. Sanitarium Cemetery — DATE OF BURIAL: 2/2 1920

20. UNDERTAKER P. M. Johnson — ADDRESS Orofino Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 29031
Registered No. 3

1. PLACE OF DEATH
County of Clearwater
City of Orofino Idaho
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Micherolis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ? (Month) ? (Day) 1? (Year)

7. AGE: about 56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Atteberry
(Address) Orofino Idaho

15. Filed Mch 20 1920
J. M. Francis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 22 1910, to Feb. 6 1920
that I last saw him alive on Feb. 6 1920
and that death occurred on the date stated above, at 8 a M.
The CAUSE OF DEATH* was as follows:
Pneumonia
about 8
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
about 18 yrs. ..... mos. ..... ds.
(Duration)
(Signed) J. Theo. A. Giuseo M. D.
2/7 1920 (Address) Orofino, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death 9 yrs. 11 mos. 16 days. In the State ? yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Shoshone, Co.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
N. D. Sanitarium Cemetery	19
20. UNDERTAKER	ADDRESS
D. M. Johnson	Orofino Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 25052
Registered No. 4

1. PLACE OF DEATH
County of Clearwater
City of Fraser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information. —

2. FULL NAME Ruth Swann Bowdish

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: April (Month) 23 (Day) 1884 (Year)

7. AGE: 35 Yrs. 9 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Ellis A. Swann

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Grace Reed

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ebbe W. Bowdish
(Address) Fraser Idaho

15. Filed Mch 20 1920 J. M. Faine Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h.r alive ½ hr before death 19.....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Pneumonia
.....(Duration) .....Yrs. .....mos. 1 ds.
Contributory (Secondary)
.....(Duration) .....yrs. .....mos. .....ds.
(Signed) Earle M Forswell M. D.
2/6 1920 (Address) Grafins Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fraser Idaho	2/7 1920
20. UNDERTAKER	ADDRESS
T. A. Thom	Grafin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 29033
Registered No. 5

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Doran
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1870 (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business or establishment in which employed (or [redacted]): 1

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: David Doran

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Briggs

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Atteberry
(Address) Orofino Ida

15. Filed Mch 20 1920
J H Hawley
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1. 1920 to Feb. 7. 1920 that I last saw h. alive on Feb. 6. 1920 and that death occurred on the date stated above, at 10 a.m. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 7. ds.

Contributory (Secondary)

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) J Thunkkunen M. D.

Feb 8 1920 (Address) Orofino, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gilbert
DATE OF BURIAL: 2/9 1920

20. UNDERTAKER: [illegible]
ADDRESS: Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 7168
File No. 23054
Registered No. 6

1. PLACE OF DEATH
County of Clearwater
City of Orofino, Ida.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlie Nelson.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ? (Month) ? (Day) 1876 (Year)

7. AGE: 44 Yrs. ? Mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Littlebury
(Address) Orofino, Ida.

15. Filed Feby 19 1920 W. M. Finch Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1919 to Jan 8 1920 that I last saw h.. alive on Jan 8 1920 and that death occurred on the date stated above, at 9 a. M.
The CAUSE OF DEATH* was as follows:

Pneumonia,

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Tuberculosis
(Duration) 5 yrs. 0 mos. 18 ds.
(Signed) John W. Simms, M. D.
2/8 1920 (Address) Orofino, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. ..... mos. 18 days. In the State ? yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ?
Former or usual residence Wallace, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: 2/ 19..

20. UNDERTAKER: H. A. Shaw — ADDRESS: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 23055
Registered No. 7

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Babcock
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	white	married (Write the word.)

6. DATE OF BIRTH: Dec 23 1 (Month) (Day) (Year)

7. AGE: 24 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Samuel Mullins

11. BIRTHPLACE OF FATHER (State or Country): Ken

12. MAIDEN NAME OF MOTHER: Mabla

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Babcock
(Address) Greenleaf, Ida

15. Filed Mch 20 1920 J. M. Hawley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 8 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 6 1920, to Feby 8 1920 that I last saw h[illegible] alive on Feby 8 1920, and that death occurred on the date stated above, at 10½ A.M.
The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Hawley M. D.
Feby 9 1920 (Address) Greenleaf, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sunset Park	9 1920
20. UNDERTAKER W. A. Shaw	ADDRESS Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 23036
Registered No. 8

1. PLACE OF DEATH
County of Clearwater
City of Orofino Idaho
If death occurred away from usual residence, give facts called for under special information.

Registration District No. 40
Primary Registration District No. 2168
(No. ..... St.)

2. FULL NAME John Dilling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH ? (Month) ? (Day) ? (Year)

7. AGE about 39 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Gilleeny
(Address) Orofino Idaho

15. Filed Mch 20 1920 J. M. Gilleeny Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1911, to February 8 1920
that I last saw him alive on Feb. 8 1920
and that death occurred on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
Don't Know,
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) ? yrs. ? mos. ..... ds.

(Signed) John M. Gilleeny M. D.
2/9 1920 (Address) Orofino Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 8 yrs. 7 mos. 19 days. In the State 9 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Don't Know.
Former or usual residence None. Tramp.

19. PLACE OF BURIAL OR REMOVAL N. D. Sanitarium Cem. | DATE OF BURIAL Feb 10 1920

20. UNDERTAKER E. M. Johnson | ADDRESS Orofino Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 23037
Registered No. 9

1. PLACE OF DEATH
County of Clearwater
City of Orofino, Idaho (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E. B. Ellsing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: About 1880 (Month) (Day) (Year)

7. AGE: About 39 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Atteberry
(Address) Orofino Idaho

15. Filed Mch 20 1920 — J. M. Faith, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 9 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1919, to Feby 9 1920 that I last saw him alive on Feby 9 1920, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Probably
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Insanity about
(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) John A. Givens M. D.
2/11 1920 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 8 yrs. 9 mos. 6 days. In the State 5 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Bonner, Co.,

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery — DATE OF BURIAL: 2/11 1920

20. UNDERTAKER: J. M. Johnson — ADDRESS: Orofino Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Clearwater

City of Orofino, Idaho.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90

Primary Registration District No. 2168

(No. ..... St.)

File No. 29038

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH ? (Month) ? (Day) 1898 (Year)

7. AGE 22 Yrs. ? Mos. ? ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ?
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) America

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Atteberry
(Address) Orofino Idaho

15. Filed Mch 20 1920 J. M. Jones Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1915, to Feb. 9 1920 that I last saw her alive on Feb. 9 1920 and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:

Epilepsy.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

..... (Duration) 5 yrs. 8 mos. ? ds.

(Signed) J. H. Atteberry M. D.

2/10 1920 (Address) Orofino, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death 5 yrs. 8 mos. 10 days. In the State ? yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ?
Former or usual residence Latah County.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 19.....
Deary Ida	
20. UNDERTAKER W. A. Shaw	ADDRESS Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 7168
File No. 29039
Registered No. 11

1. PLACE OF DEATH
County of Kootenai
City of Dalton
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward C. Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ? (Write the word.)

6. DATE OF BIRTH: ? (Month) ? (Day) 1861 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): ?

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Atteberry
(Address) Dalton Idaho

15. Filed Mch 20 1920
J. H. Vaile
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1919, to Feb 9 1920
that I last saw h~~im~~ alive on Feb 9 1920
and that death occurred on the date stated above, at 4:25 P. M.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary): Senility

(Duration) ? yrs. ? mos. ? ds.

(Signed) John C. Gimeno M. D.
3/10 1920 (Address) Dalton, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 2 mos. 20 days. In the State ? yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ?
Former or usual residence Lewis County.

19. PLACE OF ~~BURIAL~~ REMOVAL: Genesee
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: W. A. Shaw
ADDRESS: Troy

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 29040
Registered No. 12

1. PLACE OF DEATH
County of Clearwater
City of Orofino,
(No. ..... St.)
If death occurs away from usual residence give facts called for under special information.

2. FULL NAME Ed. S. Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ? (Month) ? (Day) 1850 (Year)

7. AGE: 70 Yrs. ? Mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner + Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ?

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Ida.

15. Filed Mch 20 1920 — J. M. Davis, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 11 — 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1917 to Feb. 11 — 1920 that I last saw h[illegible] alive on Feb 11 1920 and that death occurred on the date stated above, at 2-30 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia.

(Duration) 2 yrs. 6 mos. 10 ds.
Contributory (Secondary): Insanity
(Duration) 3 yrs. 7 mos. ? ds.
(Signed) J. W. Atteberry M. D.
2/11 1920 (Address) Orofino, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. 6 mos. 10 days. In the State ? yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? The N. I. Sanitarium
Former or usual residence Benewah County,

19. PLACE OF BURIAL OR REMOVAL: Latah Moth — DATE OF BURIAL: 2 1920

20. UNDERTAKER: [illegible] — ADDRESS: Orofino

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 23041
Registered No. 13

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Stevens
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
? (Month) about ? (Day) 1888 (Year)

7. AGE
32 Yrs. ? Mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farm Hand
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) America

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John A. Lowry
(Address) Orofino Idaho

15. Filed Mch 20 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1919 to Feb 19 1920 that I last saw him alive on Feb 19 1920 and that death occurred on the date stated above, at 12 40 M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. ? ds.
Contributory (Secondary) Tuberculosis ?
(Duration) ? yrs. ? mos. ? ds.

(Signed) John A. Givens M. D.
2/19/1920 (Address) Orofino Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 4 yrs. 2 mos. 2 days. In the State ? yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Nez Perce, Co.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lenore Ida	? 19

20. UNDERTAKER	ADDRESS
Hall & Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 7168
File No. 20042
Registered No. 14

1. PLACE OF DEATH
County of Canyon
City of Caldwell Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Magdalena Kauffman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Feb (Month) 16 (Day) 1838 (Year)

7. AGE
81 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) France

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) France

12. MAIDEN NAME OF MOTHER Magdalena

13. BIRTHPLACE OF MOTHER (State or Country) France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Kauffman
(Address) .....

15. Filed Mch 20 1920 — J. M. Finley — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1920, to Feb 23 1920, that I last saw her alive on Feb 23 1920, and that death occurred on the date stated above, at 10½ P.M.
The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Finley M. D.
3/23 1920 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Caldwell	3/26 1920

20. UNDERTAKER W. A. Shaw — ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 29043
Registered No. 15

1. PLACE OF DEATH
County of Clearwater
City of Orofino Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose G. Vollmeck
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: ? (Month) ? (Day) 1860 (Year)

7. AGE: 60 Yrs. ? Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Titterington
(Address) Orofino Ida

15. Filed Mch 22 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7 1920, to Feb. 24 1920 that I last saw her alive on Feb. 24 1920, and that death occurred on the date stated above, at 6:20 A. M.

The CAUSE OF DEATH* was as follows:
Arteria Sclerosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
..... (Duration) ? yrs. ..... mos. ..... ds.

(Signed) John H. Greene M. D.
2/24 1920 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 17 days. In the State 7 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Ida — DATE OF BURIAL: ? 1920

20. UNDERTAKER: H. A. Shaw — ADDRESS: Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29044

Registered No.

1. PLACE OF DEATH

County of Custer

City of Bayhorse

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 108

Primary Registration District No. 2186

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph M. Frazier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Not known (Month) (Day) 1 (Year)

7. AGE: 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ilene Tracht

(Address) Challis, Ida.

15. Filed Feb. 2d. 19 20

C. L. Kirtley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1920 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 19 20 to Feb 21 1920 19, that I last saw h.im alive on Feb 21 1920 19, and that death occurred on the date stated above, at 1 p M.

The CAUSE OF DEATH* was as follows:

Uremic coma

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Nephritis

(Duration) 8 yrs. ..... mos. ..... ds.

(Signed) C. L. Kirtley M. D.

19 ..... (Address) Challis, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Challis, Ida

DATE OF BURIAL: Feb. 23 19

20. UNDERTAKER: Friends

ADDRESS: .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Custer

City of Challis

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 108

Primary Registration District No. 2186

(No. ....., ... St.)

File No. 29045

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Allie May Stephens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
F.	Wh.	Married

6. DATE OF BIRTH

March (Month) 13 (Day) 1896 ##### 1920# (Year)

7. AGE

33 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work H-wife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Ida.

10. NAME OF FATHER

Walter E. Baxter

11. BIRTHPLACE OF FATHER

(State or Country) Ma.

12. MAIDEN NAME OF MOTHER

Mary J. McCausland

13. BIRTHPLACE OF MOTHER

(State or Country) Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary J. Baxter

(Address) Challis, Ida.

15.

Filed 2/24 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. 23rd (Month) (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/17 1920 to 2/23 1920, that I last saw her alive on 2/22 11 P. M., and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... (Address) Challis, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Challis, Ida.	2/24 1920
20. UNDERTAKER	ADDRESS
Family	

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 29047
Registered No. [redacted] 11

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Marion Daniel
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug. 9 - 1837 (Month) (Day) (Year)

7. AGE: 82 Yrs. 6 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Benton County Ill.

10. NAME OF FATHER: A. M. Daniel

11. BIRTHPLACE OF FATHER (State or Country): ——— Kentucky

12. MAIDEN NAME OF MOTHER: Harriett [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): ——— Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William M. Daniel
(Address) Mtn Home Ida

15.
Filed Feb ..... 19 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 23 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Apoplexy
" "
Sudden
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [redacted] M. D.
2-24-1920 (Address) Mountain Home

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [redacted] DATE OF BURIAL: 2-26-1920

20. UNDERTAKER: [redacted] ADDRESS: Mtn Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 29048
Registered No. 10

1. PLACE OF DEATH

County of Elmore
City of Mountain Home (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Card

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word.)

6. DATE OF BIRTH: unknown
(Month) (Day) (Year)

7. AGE: about 60 Yrs. ✓ Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: do

11. BIRTHPLACE OF FATHER (State or Country): do

12. MAIDEN NAME OF MOTHER: do

13. BIRTHPLACE OF MOTHER (State or Country): do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. O. Faraday
(Address) Mountain Home, Idaho

15. Filed Feb. 13th 1920 — B.W. Walker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 12th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 29th 1920, to Feb. 12th 1920 that I last saw him alive on Feb. 12th 1920 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Pyonephritis -
..... (Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) Influenza
..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) B.W. Walker M. D.
2/17 1920 (Address) Mountain Home Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho — DATE OF BURIAL: Feb 16th 1920

20. UNDERTAKER: A.W. Conover — ADDRESS: Mtn Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51067

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 29015
Registered No. 9

1. PLACE OF DEATH
County of Elmore
City of Mtn Home Ida (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Juan Lamiquez

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: unknown (Month) (Day) (Year)

7. AGE: 30 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheepman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Abbacegui, Vizcaya Spain

10. NAME OF FATHER: Benigno Lamiquiz

11. BIRTHPLACE OF FATHER (State or Country): Arbacegui Spain

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Agapito Bidegaray
(Address) Mtn Home Ida

15. Filed Feb. 7th 1920 — Burt Mather, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 5 — 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31st 1920, to Feb. 5th 1920
that I last saw h. him alive on Feb. 5th 1920
and that death occurred on the date stated above, at 5:00 P.M.
The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Burt Mather M. D.
2/6 1920 (Address) Mtn Home, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Ida — DATE OF BURIAL: 2-9 1920

20. UNDERTAKER: A. W. Conover — ADDRESS: Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 1119
File No. 29050
Registered No. 6

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 30 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many — hrs. or 3 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Roy Kirby

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Viola Ruth Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Curtis Blunt
(Address) Preston Idaho

15. Filed Feb 2 1920 D. A. R. Crutcher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920 to Jan 30 1920 that I last saw h— alive on Jan 30 1920 and that death occurred on the date stated above, at 7:30 M.
The CAUSE OF DEATH* was as follows:

Five months baby

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Blunt M. D.

1/31 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: 1-30-1920

20. UNDERTAKER: None
ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2118
File No. 29051
Registered No. 7

1. PLACE OF DEATH
County of Franklin
City of Weston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Lyndsworth Nielson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 27 (Day) 1919 (Year)

7. AGE: ..... Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Weston

10. NAME OF FATHER: John P. Nielson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Eva L. Lyndsworth

13. BIRTHPLACE OF MOTHER (State or Country): New Zealand

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Thomas Nielson
(Address) Weston

15. Filed Feb 26 1920 D. A. Curtis Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25 1920, to Feb 7 1920
that I last saw h.... alive on Jan 28 1920,
and that death occurred on the date stated above, at 12 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. 7 mos. ..... ds.
Contributory (Secondary) Heart trouble
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Slater M. D.
Feb 8 1920 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hyde Park Utah
DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER: C. C. Lindquist
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29052

Registered No. 8

1. PLACE OF DEATH

County of Franklin

City of Preston

(No. 9, St.)

Registration District No. 27

Primary Registration District No. 2117

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorenzo T. Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: May (Month) 25 (Day) 1864 (Year)

7. AGE: 55 Yrs. 1 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Alfred Hansen

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Marian Sewell

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) by A. J. Hansen
(Address)

15. Filed Feb 16 1920 D. A. R. Cullen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1920, to Feb 9 1920, that I last saw h.. alive on Feb 8 1920 and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis-with dropsy

(Duration) 1 Yrs. - mos. - ds.

Contributory (Secondary) Diabetes Mellitus

(Duration) 2 yrs. mos. ds.

(Signed) Albert R. Cullen M. D.

2/12 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Franklin Ida	Feb 11 1920
20. UNDERTAKER	ADDRESS
E. E. Sandquist	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Entered

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2115
File No. 29033
Registered No. E

1. PLACE OF DEATH
County of Franklin
City of Glenns Ferry Idaho (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Lorenz Auer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH July (Month) 23 (Day) 1858 (Year)

7. AGE 31 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Logan, Utah

10. NAME OF FATHER Lars C. Larson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herbert Owen
(Address) Preston Idaho R. #1

15. Filed Feb 26 1920 D. A. Rudd Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 9 1920, to Feb. 12 1920, that I last saw her alive on Feb. 11 1920, and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia-Bronchial
Type Following Influenza

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) D. A. Rudd M. D.
2/14 1920 (Address) Preston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	Feb 15 1920

20. UNDERTAKER	ADDRESS
E. Landquist	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29054
Registered No. 10

1. PLACE OF DEATH.
County of Franklin
City of Preston Ida.
Registration District No. 17
Primary Registration District No. 2 11 9
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nora Matilda Barlow

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March 13 1876 (Month) (Day) (Year)

7. AGE: 43 yrs. 11 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Woodruff Utah

10. NAME OF FATHER: Judson A. Tolman

11. BIRTHPLACE OF FATHER (State or Country): Toodle Utah

12. MAIDEN NAME OF MOTHER: Miss Howard.

13. BIRTHPLACE OF MOTHER (State or Country): Burmingham England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mathias Barlow
(Address) Preston Ida.

15.
Filed Feb. 24 1920
Dr A R Ellis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 15 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr 10 1920, to Febr 16 1920
that I last saw her alive on Febr 13 1920
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Influenza - Pneumonia

..... (Duration) ✓ yrs. ✓ mos. 4 ds.
Contributory ✓ (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W Bates M. D.
Febr 17 1920 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: Feb. 18 1920

20. UNDERTAKER: W. A. Skidmore
ADDRESS: Preston

SYMS-YORK CO., PRINTERS & BINDERS. NO. 43

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 1719
File No. 29055
Registered No. 11

1. PLACE OF DEATH

County of Franklin
City of Preston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosy Ellen Layton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH June (Month) 19 (Day) 1886 (Year)

7. AGE 33 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Noah Wilson Winger

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Ann Winger

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ann Winger

(Address) Preston Idaho

15. Filed Feb 26 1920

D. A. Cullen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febr. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr. 13 1920, to Feb. 16 1920 that I last saw her alive on Feb. 16 1920 and that death occurred on the date stated above, at 7:20 A.M.

The CAUSE OF DEATH* was as follows:

Influenza followed by Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W Slater M. D.

Feb. 18 1920 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	Feb 18 1920
20. UNDERTAKER	**ADDRESS**
L. A. Lindquist	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD-RORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Franklin
City of Treasureton (No....., ...St.)

Registration District No. 27
Primary Registration District No. 2119

File No. 29056
Registered No. 11

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arno Oswald Crockett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH: October 3 1887 (Month) (Day) (Year)

7. AGE: 32 yrs. 4 mos. 3 ds.
IF LESS than 1 day how many.....hrs. or .....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Franklin Co. Idaho

10. NAME OF FATHER: Alvin David Crockett

11. BIRTHPLACE OF FATHER (State or Country): Payson, Utah.

12. MAIDEN NAME OF MOTHER: Emma Hodges

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. D. Crockett
(Address) Treasureton Ida.

15.
Filed Feb 26 1920 D. A. Crockett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 17 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 11 1920, to Feb. 16 1920 that I last saw him alive on Feb 16 1920 and that death occurred on the date stated above, at 2 A. M.

The CAUSE OF DEATH* was as follows:

Influenza followed by Pneumonia

(Duration) 1 yrs. 1 mos. 6 ds.

Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) G. W. Slater M. D.
Feb 17 1920 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Treasureton Idaho
DATE OF BURIAL: Feb 19 1920

20. UNDERTAKER
ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29057

Registered No. 13

1. PLACE OF DEATH

County of Franklin

City of Preston

(No. ..... St.)

Registration District No. 27

Primary Registration District No. 2118

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William F. Klippenert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: Feb. (Month) 20 (Day) 1881 (Year)

7. AGE: 39 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Henrich Klippert

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Fannie Dyer

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emily Dabb

(Address) 665 27th Street Ogden

15. Filed Feb 26 1920 D. M. Rudd
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1920, to Feb 18 1920, that I last saw him alive on Feb 17 1920, and that death occurred on the date stated above, at 12:20 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza

..... (Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. M. Rudd M. D.

2/ 7 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~	DATE OF BURIAL
Preston	Feb 20 1920
20. UNDERTAKER	ADDRESS
G. A. Lindquist by E. L.	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5038
Registered No. 14

Registration District No. 27
Primary Registration District No. 1117
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Franklin
City of Preston

2. FULL NAME Theresa May Paton Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, ~~WIDOWED~~ OR ~~DIVORCED~~. (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 19 (Day) 1886 (Year)

7. AGE: 33 Yrs. 11 Mos. ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Preston Idaho

10. NAME OF FATHER: James Paton

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Rachel Hall

13. BIRTHPLACE OF MOTHER (State or Country): London Eng

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Nelson
(Address) Preston Idaho

15. Filed Feb 26 1920. Dr A Rivers Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12 1920 to Feb. 19 1920 that I last saw h.. alive on Feb. 19 1920 and that death occurred on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows:
Influenza Pneumonia

(Duration) ... Yrs. ... mos. 5 ds.
Contributory (Secondary): Consumption
(Duration) 4 Yrs. ... mos. ... ds.
(Signed) Dr A E Campbell M. D.
Feb 26 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 1 mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: 2/22 1920

20. UNDERTAKER — ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2118
File No. 29059
Registered No. 15

1. PLACE OF DEATH
County of Franklin
City of Franklin (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gordon Jones Pickett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 27 (Month) (Day) 1919 (Year)

7. AGE: X Yrs. 8 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Leland Marcus Pickett

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Stella Jones

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leland Marcus Pickett
(Address) Providence Utah

15. Filed Feb 26 1920 D. A. Quist Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1920, to Feb 20 1920, that I last saw h. l. M. alive on Feb 19 1920, and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:
Pneumonia — Pleuro

(Duration) 0 Yrs. 0 mos. 14 ds.
Contributory (Secondary) Emphysema
(Duration) 0 yrs. 0 mos. 4 ds.

(Signed) Curtis Bland M. D.
Feb 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Providence, Utah
DATE OF BURIAL: Feb 21 1920

20. UNDERTAKER: None
ADDRESS: None

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2118
File No. 29060
Registered No. 16

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvia Louisa McCombs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Single

6. DATE OF BIRTH: Jan (Month) 15 (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Preston

10. NAME OF FATHER W. A. McCombs

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Elena P. Campbell

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. McCombs
(Address) Preston

15. Filed Feb 26 1920 D. A. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920, to Feb 20 1920
that I last saw her alive on Feb 20 1920,
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Acute peritonitis

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Probably acute appendicitis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. A. Cutler Jr. M. D.
Feb 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	Feb 22 1920
20. UNDERTAKER	ADDRESS
C. Hodgson	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
File No. 29061
Registered No. 15

2. FULL NAME Dora Orpha Wilcox
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 23 (Day) 1912 (Year)

7. AGE: 7 Yrs. 8 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Harvey Wilcox

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Dora Mable Mickelson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Harvey Wilcox
(Address) Preston, Idaho

15. Filed Feb 28 1920 D. A. Coultis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1920, to Feb 14 1920, that I last saw h.. alive on Feb 13 1920, and that death occurred on the date stated above, at 7:15 A.M.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) 0 Yrs. 0 mos. 12 ds.
Contributory (Secondary) Empyema
(Duration) 0 yrs. 0 mos. 4 ds.

(Signed) Curtis Bland M. D.
2/15/1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston, Idaho
DATE OF BURIAL: 2-15-1920

20. UNDERTAKER: Skidmore
ADDRESS: Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29062
Registered No. 18

1. PLACE OF DEATH
County of Franklin Registration District No. 27
Primary Registration District No. 2118
City of Franklin (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Fukumura
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH June 13 1919
(Month) (Day) (Year)

7. AGE Yrs. 7 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Franklin

10. NAME OF FATHER Andrew Fukumura

11. BIRTHPLACE OF FATHER (State or Country) Providence

12. MAIDEN NAME OF MOTHER Effie Jones

13. BIRTHPLACE OF MOTHER (State or Country) Providence

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph H. Fukumura
(Address) Providence, Utah

15. Filed Feb. 28 1920 D. A. Rudd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 26 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1920, to Feb 26 1920, that I last saw h.e. alive on Feb 25, 1920, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
..... (Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) Meningitis
..... (Duration) ..... yrs. ..... mos. 1 ds.
(Signed) Curtis Bland M. D.
2-27 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Franklin	Feb 29 1920

20. UNDERTAKER	ADDRESS
G. A. Sandquist	Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 29063
Registered No. 19

1. PLACE OF DEATH
County of Franklin
City of Preston Ada (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ellen Robbins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1884 (Year)

7. AGE: 35 Yrs. 4 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Heard

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Henry E. Webb.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Zina Hurd
(Address) Smoot, Wyo.

15. Filed ..... 19 .....
D. A. R. Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1920 to Feb 26 1920 that I last saw her alive on Feb 26 1920 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Influenza Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Holden M. D.
Feb 26 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Smoot Wyo
DATE OF BURIAL: 3/3 1920

20. UNDERTAKER: [illegible]
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29064
Registered No. 20

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119

2. FULL NAME Charles Edward Alexander

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 17 (Month) (Day) 1906 (Year)

7. AGE: 13 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Edward Alexander

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Catherine Cromer

13. BIRTHPLACE OF MOTHER (State or Country): U. S. America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. P. Nelson
(Address) Preston Ida

15. Filed Mar 9 1920 D. A. Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 29 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920, to Feb 29 1920, that I last saw h.im alive on Feb 29 1920, and that death occurred on the date stated above, at 6.25 P.M.
The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Curtis Blank M. D.
3/1 1920 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	1920
20. UNDERTAKER	ADDRESS
Grandpa Hurd	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29065

Registered No. 21

1. PLACE OF DEATH

County of Franklin

City of Franklin

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ezra Lewis Fuhriman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Married

6. DATE OF BIRTH: July 1 1887 (Month) (Day) (Year)

7. AGE: 32 Yrs. 7 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Providence

10. NAME OF FATHER: Jacob Fuhriman

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Mary Tousley

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Joseph N. Fuhriman
(Address): Providence, Idaho

15. Filed Mar 3 1920 D. A. Coulter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920, to Feb 28 1920, that I last saw h.im alive on Feb 28 1920, and that death occurred on the date stated above, at 12:10 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary): La Grippe

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Curtis Bland M. D.

3/1 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Franklin — DATE OF BURIAL: Mar 2 1920

20. UNDERTAKER: G. H. Sandgren — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 29066
Registered No. 22

1. PLACE OF DEATH
County of Franklin
City of Banida (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Anderson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): M

6. DATE OF BIRTH: Sept (Month) 22 (Day) 1880 (Year)

7. AGE: 40 Yrs. 4 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Henry Dickson

11. BIRTHPLACE OF FATHER (State or Country): U.S.A.

12. MAIDEN NAME OF MOTHER: Amelia Garner

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter L. Dyson
(Address) Preston Ida

15. Filed Mar 4 1920 D. A. Rullus Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 2 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920, to Feb 2 1920, that I last saw her alive on Jan 31 1920, and that death occurred on the date stated above, at 11 45 M.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 13 ds.

(Signed) A. P. Cutler M. D.
19..... (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clifton
DATE OF BURIAL: Feb 5 1920

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 29067
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Ideadale (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecil Brower
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Jan (Month) 5 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 3 hrs. and 10 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Joseph Elmer Brower

11. BIRTHPLACE OF FATHER (State or Country): Cache Co Utah

12. MAIDEN NAME OF MOTHER: Bertha Adeline Hardy

13. BIRTHPLACE OF MOTHER (State or Country): Hooper Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Elmer Brower
(Address) Ideadale Idaho

15. Filed Mar 10 1920 W O Wrax
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to Jan 5 1920, that I last saw h.sm alive on Jan 5 1920, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth and
Atelectasis
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earl Francis M. D.
Jan 5 1920 (Address) Star Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford
DATE OF BURIAL: Jan 6 1920

20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 29068
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ingrid Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: November 4 (Month) (Day) 1858 (Year)

7. AGE: 62 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew Larson

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Kjerstin Underson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ellen J. Murri
(Address) St. Anthony, Ida.

15. Filed Nov 10 1920 W S Evert Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25th 1920, to Jan 30th 1920, that I last saw h[illegible] alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Multiple Neuritis
Chr Cardiac Valvular disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr J. Frank Watkins M. D.
Jan 31 1920 (Address) St Anthony, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Willard Ida. | DATE OF BURIAL 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 23069
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laurence Joseph Plant
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	W.	Single

6. DATE OF BIRTH
~~Feb.~~ June 25 1918
(Month) (Day) (Year)

7. AGE
1 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Butte, Mont.

10. NAME OF FATHER James J. Plant

11. BIRTHPLACE OF FATHER (State or Country) Wis.

12. MAIDEN NAME OF MOTHER Bridget Ryan

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James J. Plant
(Address) St. Anthony

15. Filed Mar 10 1920 W. D. Lee
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 21 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1920 to Feb 20 1920
that I last saw h..... alive on ..... 19....,
and that death occurred on the date stated above, at 3:30 a M.
The CAUSE OF DEATH* was as follows:
Influenza.
Bronchopneumonia.
(Duration) ... Yrs. ... mos. 3 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) J. Frank Watkins M. D.
Feb 21 1920 (Address) St Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 8 mos. ... days. In the State ... yrs. 8 mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence St. Anthony

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Anthony City Cemetery	Feb. 23 1920
20. UNDERTAKER	ADDRESS
Taylor-Elsom Mortuary	St. Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 3070
Registered No.

1. PLACE OF DEATH

County of Fremont
City of St Anthony
(No. Babbitt St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leonard B. Rice, Jr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 9 (Day) 1896 (Year)

7. AGE: 23 Yrs. 9 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Leonard B. Rice

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Stoddard

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L. B. Rice Sr.
(Address) St Anthony

15. Filed Mch 10 1920 W. A. Wrat Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 10 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10 1920 to Feb. 10 1920 that I last saw h[illegible] alive on Feb. 10 1920 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 1½ ds.

(Signed) J. E. Whitney M. D.

Feb. 17 1920 (Address) St Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State Lyn Butte yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence St. Anthony Idaho.

19. PLACE OF BURIAL OR REMOVAL: Parker Cemetery | DATE OF BURIAL: Feb 12 1920

20. UNDERTAKER: Taylor-Elsom Undtg. | ADDRESS: St. Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 29071
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St. Anthony
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leonard Babbitt Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: April (Month) 1 (Day) 1850 (Year)

7. AGE: Yrs. 69 Mos. 10 ds. 15
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Leonard G. Rice

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Babbitt

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L. B. Rice Sr.
(Address) St. Anthony

15. Filed Mch 10 1920 W B Ward
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 15" (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13" 1917, to Dec 9" 1919
that I last saw him alive on Dec 9" 1919
and that death occurred on the date stated above, at 6.15 A. M.
The CAUSE OF DEATH* was as follows:

Debility

(Duration) ..... Yrs. 18 mos. ..... ds.

Contributory (Secondary) Bone injury of hip with caries of bone
Enlarged prostate - cystic stone

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) M. M. Marshburger M. D.
19..... (Address) St. Anthony, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 36 yrs. ..... mos. ..... days. In the State 36 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence St. Anthony

19. PLACE OF BURIAL OR REMOVAL: Parker Cemetery — DATE OF BURIAL: Feb. 18 1920

20. UNDERTAKER: Taylor-Peterson Und. Co — ADDRESS: St. Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2197
File No. 29072
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Ashton
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clyde Delmar Fowler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: N (Month) 6 (Day) 19 20 (Year)

7. AGE: Yrs. Mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idy

10. NAME OF FATHER: Frank Fowler

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Bertha Sorrels

13. BIRTHPLACE OF MOTHER (State or Country): Idy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Fowler
(Address) at Ashton Idy

15. Filed Nov 10 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: N (Month) 16 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from N 6 19 20, to N 16 19 20
that I last saw he alive on N 16 19 20,
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) Infection umbilicus

(Duration) yrs. mos. 7 ds.

(Signed) Frank Gray M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker
DATE OF BURIAL: N 19 20

20. UNDERTAKER: none
ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29073

Registered No.

1. PLACE OF DEATH

County of Fremont

City of Chester

(No. ....., ... St.)

Registration District No. 99

Primary Registration District No. 2177

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Richard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: 5 (Month) 25 (Day) 1847 (Year)

7. AGE: 72 Yrs. 9 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): wales

10. NAME OF FATHER: william Richards

11. BIRTHPLACE OF FATHER (State or Country): wales

12. MAIDEN NAME OF MOTHER: Elizabeth Bowen

13. BIRTHPLACE OF MOTHER (State or Country): wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Rachus Peterson

(Address) st anthony Idaho

15. Filed Nov 10 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/12 1920, to 7/12 1920 that I last saw him alive on 7/11 1920, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

few min

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory (Secondary) Indigestion

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Jno R Gray M. D.

7/13 1920 (Address) st anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: milford — DATE OF BURIAL: 7/14 1920

20. UNDERTAKER: Hansen — ADDRESS: St Anthony Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont

City of Chester

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2177

(No. ..... St.)

File No. 23074

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lionel Clifford Hathaway

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH

June (Month) 9 (Day) 1888 (Year)

7. AGE

31 Yrs. 11 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Teton City Ida

10. NAME OF FATHER J.W. N. Hathaway

11. BIRTHPLACE OF FATHER (State or Country) Pa

12. MAIDEN NAME OF MOTHER Ada Clifford

13. BIRTHPLACE OF MOTHER (State or Country) Providence Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. C. Howard

(Address) Chester Ida

15. Filed Nov 10 1920

W Burrell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920, to July 25 1920, that I last saw him alive on July 25 1920, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) "Flue"

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Burrell M. D.

19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chester Ida

DATE OF BURIAL: July 27 1920

20. UNDERTAKER: None

ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 29075
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Eliza Orr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: 8 (Month) 23 (Day) 1879 (Year)

7. AGE: 40 Yrs. 4 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Chas Lyons

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Bull

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas Orr
(Address) St Anthony Ida

15. Filed Feb 10 1920 W B Wix Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 9 1920, to Jan 17 1920 that I last saw her alive on Jan 11 1920, and that death occurred on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 1 Yrs. mos. ~~hrs~~ ds.

Contributory (Secondary) Gall stone colic

(Duration) yrs. mos. 3 ds.

(Signed) Jno C Gray M. D.

1/16 1920 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker Ida — DATE OF BURIAL: 1/16 1920

20. UNDERTAKER: Home — ADDRESS: Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5 3
Primary Registration District No. 2009 2005
File No. 29077
Registered No. 43

1. PLACE OF DEATH
County of Gem
City of New Plymouth (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Hilger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: May (Month) 6 (Day) 1855 (Year)

7. AGE: 64 Yrs. 11 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife –
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Fodder

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hartpach

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [signature]
(Address) New Plymouth

15. Filed Mch 4 1920
[signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 13 - 1920, to Mch 2 1920, that I last saw her alive on Feb 15 1920, and that death occurred on the date stated above, at 7:40 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis –

~~Dementia~~ –

(Duration) ~~Several~~ Yrs. ..... mos. ..... ds.

Contributory (Secondary) Dementia

(Duration) ..... yrs. ~~several~~ mos. ..... ds.

(Signed) Wm J. Drysdale M. D.

3-4 1920 (Address) New Plymouth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: MAR 4 1920

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gem — Registration District No. 1616 — File No. 29078

City of Emmett — Primary Registration District No. — Registered No.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Lafayette Markham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Infant

6. DATE OF BIRTH: Jan (Month) 14 (Day) 1920 (Year)

7. AGE: — Yrs. 1 Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: P. E. Markham

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Lucile Maddox

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. E. Markham
(Address) Emmett Idaho

15. Filed 2/18 1920 — J. D. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920, to Feb 14 1920, that I last saw h— alive on Feb 13 1920, and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.

2/18 1920 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL: 2/14 1920

20. UNDERTAKER: C. D. Buckner — ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gem

City of Emmett

Registration District No.

Primary Registration District No. 1028

(No. ..... St.)

File No. 29079

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Hiel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: May 9 1 (Month) (Day) (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Ornamental

(b) General nature of industry, business or establishment in which employed (or employer): Confectionery

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Alexander Hiel

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs R.N. Brubaker

(Address) .....

15. Filed 2/19/ 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920 to Feby 3 1920, that I last saw h[illegible] alive on Feby 3 1920, and that death occurred on the date stated above, at 7 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) R N Cummings M. D.

2/5 1920 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: C D Buckmun

ADDRESS Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

6

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1020

(No. , St.)

File No. 29080

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Dymoke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widow

6. DATE OF BIRTH: Feb 4 1853 (Month) (Day) (Year)

7. AGE: 67 Yrs. — Mos. 17 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Brimhall

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W P Dymoke

(Address) Midvale Idaho

15.

Filed 19

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 21 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1920, to Feb 21 1920 that I last saw h.. alive on Feb 19 1920, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary): Influenza

(Duration) yrs. mos. ds.

(Signed) J L Reynolds M. D.

2/29 1920 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Idaho

DATE OF BURIAL: 2/22 1920

20. UNDERTAKER: O L Buckmun

ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 2014
File No. 29081
Registered No. .....

1. PLACE OF DEATH.
County of Gooding
City of Gooding
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy Riichi Taniguchi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. March 6 1887 (Month) (Day) (Year)
7. AGE: 32 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Cook
(b) General nature of industry, business, or establishment in which employed (or employer)... Cafe
9. BIRTHPLACE (State or Country) Japan
10. NAME OF FATHER Masamon Taniguchi
11. BIRTHPLACE OF FATHER (State or Country) Japan
12. MAIDEN NAME OF MOTHER Masa Doi
13. BIRTHPLACE OF MOTHER (State or Country) Japan
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry Taniguchi
(Address) Gooding Idaho
15.
Filed 2-23- 1920 F. C. Cary M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 22 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920, to Feb 22 1920, that I last saw h alive on Feb. 22 1920 and that death occured on the date stated above, at 2.30 A M.
The CAUSE OF DEATH* was as follows:
Pneumonia following cold.
(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) Pneumonia
Cold (Duration ..... yrs. ..... mos. ..... ds.
(Signed) H. C. Lamb by H N D M. D.
2/22 1920 (Address) Gooding Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 6 mos. ..... days. In the State 11 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Japan

19. PLACE OF BURIAL OR REMOVAL: Portland Oregon — DATE OF BURIAL: 2-25-1920
20. UNDERTAKER: C. E. Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 24

Primary Registration District No. 2014

File No. 29082

County of Gooding

City of Gooding (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eva J. Bridgman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH: December 28 (Month) (Day) 1861 (Year)

7. AGE: 58 yrs. 1 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife.
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Robert Miller

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Miss Strain

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. Bridgman
(Address) Gooding Ida

15. Filed 2-23- 1920 F.F. Cary M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 2 1919, to Feb. 20 1920, that I last saw h[illegible] alive on Feb. 20 1920 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac Failure
Paralysis
Hardening of spinal cord
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) 2 yrs. ..... mos. ..... ds.

(Signed) T. A. Johnson M. D. C. M. D.
2-21 1920 (Address) Gooding Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida | DATE OF BURIAL: 2-23-1920

20. UNDERTAKER: A. E. Hoopes | ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

2-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29083

Registered No. .....

Registration District No. 24

Primary Registration District No. 1014

(No. ..... St.)

1. PLACE OF DEATH.

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. Franklin Hoover

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Sept. (Month) 23 (Day) 1854 (Year)

7. AGE: 65 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Emanuel Hoover

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gilbert L. Hoover

(Address) Gooding Idaho

15.

Filed 2-22- 1920

H. Cary M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep. 9th 1919, to Feb. 20 1920, that I last saw h sm alive on Feb 19 1920 and that death occured on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Arteriosclerosis

(Duration 7 yrs. ..... mos. ..... ds.

(Signed) H. E. Powell M. D.

19..... (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Gooding Idy — DATE OF BURIAL: 2-22 1920

20. UNDERTAKER: G. E. Thompson — ADDRESS: Gooding

STAR - YORK CO., PTRS. & DRGS. 24658

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 23084
Registered No.

1. PLACE OF DEATH.
County of Gooding
City of Gooding (No., St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24
Primary Registration District No. 2014

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Martha Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: December 11 1887 (Month) (Day) (Year)

7. AGE: 32 yrs. 1 mos. 10 ds. IF LESS than 1 day how many ..... *hrs.* or ..... *min.*?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: George Peterson

11. BIRTHPLACE OF FATHER (State or Country): New Jersey

12. MAIDEN NAME OF MOTHER: Elizabeth Robinson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Moore
(Address) Hagerman

15. Filed 1-26-1920 F. T. Carey M.D.
~~Local~~ Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 21 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 17 1920, to January 21 1920, that I last saw her alive on January 21 1920, and that death occurred on the date stated above, at 12:20 M.

The CAUSE OF DEATH* was as follows:
General Peritonitis

(Duration) yrs. mos. 4 ds.
Contributory (Secondary) Local pelvic peritonitis and Nephritis
(Duration) yrs. mos. 21 ds

(Signed) F. C. Carey M. D
January 21 1920 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman — DATE OF BURIAL: Jan 24 1920

20. UNDERTAKER: A. E. Hampson — ADDRESS: Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 2014
File No. 29085
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Gooding
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm. Wallace Caldwell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 30 (Day) 1857 (Year)

7. AGE: 63 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Engineer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: John A. Caldwell

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Elyabeth Coontz

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. O. Caldwell
(Address) Gooding Idaho

15. Filed 1/22 1920 F. L. Carey M. D.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 22 1919, to Jan 22 1920 that I last saw h[illegible] alive on Jan 1 1920 and that death occurred on the date stated above, at 4 A M.
The CAUSE OF DEATH* was as follows:
Chronic Brights Disease
(Duration) 2 Yrs. ' mos. - ds.
Contributory (Secondary) Mitral insufficiency
(Duration) 2 yrs. mos. ds.
(Signed) J. A. Caldwell M. D.
1/28 1920 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: 1-27 1920

20. UNDERTAKER: G. E. Thompson — ADDRESS: 1-22-20

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 24
County of Gooding Primary Registration District No. 1914
City of Gooding (No. ....., ... St.) File No. 29086
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Benjamin Potter Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: Nov. (Month) 7 (Day) 1833 (Year)
7. AGE: 86 yrs. 1 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired farmer
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Bear River - Nova Scotia
10. NAME OF FATHER: Henry Potter
11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia
12. MAIDEN NAME OF MOTHER: Mary Rice
13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Elizabeth Carson
(Address) Gooding, Idaho
15.
Filed 1-3 1920 Hedy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 9 1919, to Dec. 27 1919
that I last saw him alive on Dec 27 1919,
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows: Chronic prostatitis and cystitis
(Duration) 5 yrs. ..... mos. ..... ds.
Contributory (Secondary) old age -
(Duration) [redacted] yrs. ..... mos. ..... ds.
(Signed) H. E. Lamb M. D.
Jan 3 1920 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats 1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moulton Home — DATE OF BURIAL: 1-5 1920
20. UNDERTAKER: A E Thompson — ADDRESS: Gooding Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29089
Registered No.

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24
Primary Registration District No. 1024
(No. ....., ... St.)

2. FULL NAME Mildred Ballard

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: April (Month) 17 (Day) 1890 (Year)

7. AGE: 29 yrs. 9 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Charles Cleveland

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Letty Miller

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Cleveland
(Address) Gooding Idaho

15.
Filed Jan — 19 — 1920 F. F. Cary M. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1920 to January 17 1920
that I last saw h[illegible] alive on Jan. 17 1920,
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Embolism
30 min.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Septremia
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) F. E. Lamb M. D.
Jan. 19 1920 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone Ida
DATE OF BURIAL: Jan — 20 — 1920
20. UNDERTAKER: E. E. Thompson
ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29090
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Idaho
City of Woodland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. 2128
(No. ..... St.)

2. FULL NAME Henry Hudson McCoy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. Dec 11 (Month) (Day) 1863 (Year)
7. AGE: 57 Yrs. 2 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: George W McCoy
11. BIRTHPLACE OF FATHER (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: May ..... Dont Know
13. BIRTHPLACE OF MOTHER (State or Country): Dont Know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jane M Batch
(Address) Newberg Oregon
15. Filed 3/5 1920 J J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 4 (Month) (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan. 1919, to March 1920, that I last saw him alive on 3/4 1920, and that death occured on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Nephritis, Interstitial
.....
.....
(Duration) Yrs. 6 mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Bryan M. D.
3/6 1920 (Address) Woodland

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Olney Springs - Col. DATE OF BURIAL ..... 191..
20. UNDERTAKER: C J Johnson ADDRESS Kennick Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29091
Registered No. .....

Registration District No. 49
Primary Registration District No. 2128
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Idaho
~~City or~~ Cambelfield

2. FULL NAME Lottie York

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. January 30 1902
(Month) (Day) (Year)

7. AGE: 17 Yrs. ..... Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: L. L. York.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Julia Moore

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Claud Adams
(Address) Kamiah Ida

15. Filed 2/13 1920
G. Johnson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...
and that death occured on the date stated above, at 6.45A M.
The CAUSE OF DEATH* was as follows:

No Doctor

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Willow Hill Cem Idaho Co — DATE OF BURIAL: 2/16 1920

20. UNDERTAKER: E. G. Hinson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 1001

File No. 29092
Registered No. 12

2. FULL NAME John Grant Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. January 13 1842
(Month) (Day) (Year)

7. AGE: 77 Yrs. ... Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Home Co Pennsylvania

10. NAME OF FATHER: Josiah Howard

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Nancy Rhoads

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miriam Howard
(Address) Grangeville Idaho

15. Filed March 5 1920
G B Stricklin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 2 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Feb. 2 1920, that I last saw h.. alive on Feb 2 1920, and that death occured on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) O W Clemens M. D.
2/3 1920 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Feb 4 1920

20. UNDERTAKER: A J Mauzy
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, with pen and ink. Do not use pencil.

BYRNE - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 29093
Registered No. 11

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ethel Manning

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Nov. (Month) 25 (Day) 1887 (Year)

7. AGE
31 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Henry W Ayler

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Robertson

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. W. Manning
(Address) Grangeville - Ida.

15.
Filed March 5 1920
G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1919 to Feb 1 1920, that I last saw h[illegible] alive on Feb 1 1920 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R Adler M. D.
2/2 1920 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Feb. 3 1920

20. UNDERTAKER: A. J. Mangg
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24655

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 29094
Registered No. 10

1. PLACE OF DEATH.
County of Idaho
City of Brangeville
(No. .... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fannie Markham

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowe

6. DATE OF BIRTH. Sept. (Month) 7 (Day) 1835 (Year)

7. AGE: 84 Yrs. 5 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Laport Indiana

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Wm Braybrook
(Address) Brangeville Ida

15.
Filed March 3 1920 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to Feb 8 1920, that I last saw her alive on Feb 8 1920, and that death occured on the date stated above, at 11 P, M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.
2/9 1920 (Address) Brangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER: E. S. Hancock — ADDRESS: Brangeville

SVMB - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
(No. .... St.)

File No. 29095
Registered No. 9

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tine Korthuis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. March (Month) 9 (Day) 1884 (Year)

7. AGE: 35 Yrs. 10 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Holland

10. NAME OF FATHER: John VandenWall

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Cornelia Van Dyk

13. BIRTHPLACE OF MOTHER (State or Country): Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Korthuis
(Address) Grangeville

15.
Filed March 3 1920 G S Stockton Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1920, to Feb 3 1920, that I last saw her alive on Feb 3 1920, and that death occured on the date stated above, at 12:20 P.M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Influenza
(Duration ..... yrs. ..... mos. 10 ds.
(Signed) G S Stockton M. D.
2/4 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairieview
DATE OF BURIAL: Feb 7 1920

20. UNDERTAKER: A J Mangg
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 29096
Registered No. 7

1. PLACE OF DEATH.
County of Idaho
City of Harpster
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George P McComas
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH. March (Month) 28 (Day) 1857 (Year)

7. AGE: 62 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Springfield. Ill.

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Springfield. Ill

12. MAIDEN NAME OF MOTHER: [illegible] Mrs. McComas

13. BIRTHPLACE OF MOTHER (State or Country): ~~Springfield~~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J B McComas
(Address) Harpster, Idaho

15. Filed Mch 1 1920. G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Acute dilation of Heart
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Old Age
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A J Mauzy Coroner M. D.
2/14 1920 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harpster — DATE OF BURIAL: Feb. 16 1920.

20. UNDERTAKER: A J Mauzy — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 29097
Registered No. 6

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Addie Alice Nail

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 19 (Day) 1887 (Year)

7. AGE: 32 Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: James H Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Elvira Rice.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Roy Nail
(Address) Grangeville

15. Filed March 3 1920 G B Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920, to June 29 1920, that I last saw her alive on June 29 1920, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Influenza
(Duration 12 yrs. mos. ds.
(Signed) B C Chipman M. D.
3-2 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View. DATE OF BURIAL: Feb 3 1920

20. UNDERTAKER: G J Mangg ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29098

Registered No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Edward Mc Pherson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. April (Month) 6 (Day) 1867 (Year)

7. AGE: 57 Yrs. 9 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Stephen Mc Pherson

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. I HEREBY CERTIFY, THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred C Kaucheker

(Address) Grangeville Idaho

Filed Feb 1 1920

G S Slick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920, to Jan 29 1920, that I last saw him alive on Jan 29 1920, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Ptomaine

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R P Downey M. D.

1/29 1920 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Jan 30 1920

UNDERTAKER: E S Hancock — ADDRESS: Grangeville

UNFADABLE INK—THIS IS A PERMANENT RECORD. ... should be carefully ... plied. AGE should be stated EXACTLY, PHYSICIANS ... be careful ... that it may be properly classified. Exact statement ... in plain terms, ... TION is very important. ... instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 29099
Registered No. 4

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elias C Cobb.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. March (Month) 25 (Day) 1836 (Year)

7. AGE: 83 Yrs. 9 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Massachusetts

10. NAME OF FATHER Collins Cobb

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W N Scales
(Address) City.

15. Filed March 1 1920 G. S. Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1919, to Jan 9 1920, that I last saw him alive on Jan 7 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Senile Decay.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

1/10 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: Jan 12 1920

20. UNDERTAKER: A J Mauzy
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2910

Registered No. 3

1. PLACE OF DEATH.

County of Idaho

City of Grangeville

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103

Primary Registration District No. 1001

2. FULL NAME George David Stanberry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. January (Month) 20 (Day) 1871 (Year)

7. AGE: 49 Yrs. ..... Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bodard to Missouri

10. NAME OF FATHER: James M Stanbery

11. BIRTHPLACE OF FATHER (State or Country): Illonois

12. MAIDEN NAME OF MOTHER: Semanthy Ogelsbee

13. BIRTHPLACE OF MOTHER (State or Country): Illonois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mabel Haythurst

(Address) Wyrona Ida

15. Filed Mch 1 1920 G S Stricklin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920, to Feb 3 1920, that I last saw him alive on Feb 3 1920, and that death occured on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Spanish Influenza

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G S Stricklin M. D.

2/5 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Winona

DATE OF BURIAL: Feb. 7th 1920

20. UNDERTAKER: E S Hancock

ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 1001
File No. 7 29101
Registered No. 2

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Moffet Cowan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	married

6. DATE OF BIRTH.
March (Month) 3d (Day) 1854 (Year)

7. AGE
65 Yrs. 10 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Goncala bo Oregon

10. NAME OF FATHER Robert Cowan

11. BIRTHPLACE OF FATHER
(State or Country) Scotland

12. MAIDEN NAME OF MOTHER Caroline Jories

13. BIRTHPLACE OF MOTHER
(State or Country) Mosurra

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Hugh Cowan
(Address) Grangeville

15.
Filed Feb 1 1920
G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1919, to Jan 19 1920, that I last saw h~~im~~ alive on Jan 17 1920, and that death occured on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) G S Stockton M. D.
1/20 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kamiah	Jan 22 1920

20. UNDERTAKER	ADDRESS
E S Hancock	Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1007
(No. ....., ... St.)

File No. 29102
Registered No. 1

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura A Heath

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Jan (Month) 8 (Day) 1852 (Year)

7. AGE: 67 Yrs. 7 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Alex Kirk

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Emiline Arnhart

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Thomas J Heath. Grangeville

15. Filed Jan 1 1920 Gastrickin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1919, to Jan 8 1920, that I last saw her alive on Jan 8 1920, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis

(Duration) — Yrs. — mos. 11 ds.
Contributory (Secondary) Inflamation, Rheumatism

(Duration) 1 yrs. 3 mos. — ds.
(Signed) G. S. Stockton M. D.
1/9 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver
DATE OF BURIAL: 1-10 1920

20. UNDERTAKER: E S Hancock
ADDRESS: Grangeville

BYRNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29103

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 105

Primary Registration District No. 2183

File No. 2

County of Idaho

City of Ferdinand (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella May Dingley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 4 (Day) 1889 (Year)

7. AGE: 30 Yrs. 6 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Neb

10. NAME OF FATHER: Loyd F Collier

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Lena Richardson

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Lena Collier
(Address) Ferdinand

15. Filed Jany 30 1920 W B Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920, to Jan 28 1920, that I last saw her alive on Jan 28 1920, and that death occured on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Embolism, Cerebral Jan 21 and died suddenly with no premunitory symptoms.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cerebral Hemorrhage
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Virgil E. Alsop M. D.
1/29 1920 (Address) Ferdinand Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Ferdinand

19. PLACE OF BURIAL OR REMOVAL: Cottonwood — DATE OF BURIAL: 1-30 1920

20. UNDERTAKER: H H Nau — ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29104

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

File No. 3
Registered No. .....

1. PLACE OF DEATH.

County of Idaho
City of Kootenai

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kathrine Mader

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 28 (Day) 1873 (Year)

7. AGE: 46 Yrs. 8 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Jacob Trautman

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Cathrine Borenbeck

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Stephen E Trautman
(Address) Cottonwood Idaho

15.
Filed Feby 4 1920 H B Blake Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1920, to Feb 4 1920, that I last saw her alive on Feb. 3rd 1920, and that death occured on the date stated above, at 9.50 A.M.

The CAUSE OF DEATH* was as follows:
Influenza Pneumonia

(Duration) 1 Yrs. ..... mos. 4 ds.

Contributory (Secondary) Hyperthyroidism

(Duration 2 yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.

2-5 1920 (Address) Cottonwood

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kenteiville Ida — DATE OF BURIAL: 2-5 1920

20. UNDERTAKER: J M Nass — ADDRESS: Cottonwood Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Kentonville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

File No. 4 29105
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bernardina Gehring

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 15 (Day) 1867 (Year)

7. AGE: 52 yrs. 4 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Prussia

10. NAME OF FATHER: Werner Herzog

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Prussia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bernard N. Gehring
(Address) Kentonville Idaho

15.
Filed Feby 11 1920 H Booker
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feby (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 6th 1920, to Feby 11 1920, that I last saw her alive on Feby 11 1920 and that death occurred on the date stated above, at 5 20 P.M.

The CAUSE OF DEATH* was as follows:
Influenza-Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Booker M. D.
2/11/20 (Address) Cottonwood, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kentonville Idaho
DATE OF BURIAL: Feby 14 1920

20. UNDERTAKER: R. L. Nash
ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5 29106

Registered No. .....

1. PLACE OF DEATH.

County of Idaho

City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anthony Ross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 17 (Day) 1885 (Year)

7. AGE: 34 Yrs. 2 Mos. 25 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER John Ross

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Gertrude Sullivan

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Ross

(Address) Cottonwood Idaho

15.

Filed Feb 12 1920

H W Bell
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 7 1920, to Feb. 11 1920, that I last saw him alive on Feb 10 1920, and that death occured on the date stated above, at 1200 M.

The CAUSE OF DEATH* was as follows:

Influenza - Pneumonia

.....(Duration) ..... Yrs. ~ mos. 7 ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Thos F Orr M. D.

2/11 1920 (Address) Cottonwood Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferdyman Idy — DATE OF BURIAL: 2-12 1920

20. UNDERTAKER: Allan — ADDRESS: Cottonwood Idy

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 6

Registered No. 29107

1. PLACE OF DEATH.

County of Idaho

City of Ferdinand

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry J Kuther

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. April (Month) 10 (Day) 1891 (Year)

7. AGE: 28 Yrs. 10 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Henry Kuther

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Catherine Oberbeck

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert [illegible]

(Address) Ferdinand Idaho

15.

Filed Feby 17 1920

[illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15-6 P.M. 1920 to Feb-15 10 P.M. 1920, that I last saw him alive on Feb-15 1920 and that death occured on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza-Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) —

(Duration — yrs — mos. ..... ds.

(Signed) Wesley F. Orr M.D.

2/16 1920 (Address) Cottonwood Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferdinand Ida — DATE OF BURIAL: 2-18 1920

20. UNDERTAKER: [illegible] Orr — ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29108

Registered No. .....

1. PLACE OF DEATH.

County of Idaho

City of Kootenville

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Magdalena Winkler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 30 (Day) 1858 (Year)

7. AGE: 61 Yrs. 4 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: — — Weigel

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank G Winkler
(Address) Cottonwood

15.
Filed Feby 19 1920 H B Blake Local Registrar

SYMS - YORK BG., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12 1920, to Feb. 18 1920, that I last saw her alive on Feb. 18 1920, and that death occured on the date stated above, at 4.20 P.M.

The CAUSE OF DEATH* was as follows:
Influenza Pneumonia

(Duration) 1 Yrs. mos. 8 ds.
Contributory (Secondary) Influenza
(Duration 7 yrs.) mos. 4 ds.

(Signed) Wesley F Orr M. D.
2/21 1920 (Address) Cottonwood Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kootenville Cem — DATE OF BURIAL: 2-25 1920

20. UNDERTAKER: C. L. Mau — ADDRESS: Cottonwood Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 8

Registered No. 29109

1. PLACE OF DEATH.

County of Idaho

City of Kentuville (No. ....., ... St.)

Registration District No. 105

Primary Registration District No. 2183

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank J Winkler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 26 (Day) 1849 (Year)

7. AGE: 70 Yrs. 4 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER — Winkler

11. BIRTHPLACE OF FATHER (State or Country) Austrian

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Austrian

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank G Winkler

(Address) Cottonwood

15.

Filed Feby 19 1920 H Mosher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12 1920, to Feb. 18 1920, that I last saw him alive on Feb. 18 1920, and that death occured on the date stated above, at 11.30P M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) —

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.

2/20 1920 (Address) Cottonwood Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kentuville Ida — DATE OF BURIAL: 2 v 20 1920

20. UNDERTAKER: C. H. Nave. — ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 9
Registered No. 29110

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Anna Kopczynski

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Sept (Month) ..... (Day) 1854 (Year)

7. AGE: 65 Yrs. 5 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Aug. Kopczynski
(Address) Cottonwood Idaho

15.
Filed July 19 1920 H. W. Blake
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1st 1920, to Feb. 18 1920, that I last saw her alive on Feb. 17 1920 and that death occured on the date stated above, at 6:30 P. M.

The CAUSE OF DEATH* was as follows:
Senile degeneration
.....
.....
(Duration) 1 Yrs. 4 mos. — ds.
Contributory (Secondary) Hypothyroidism
(Duration) 3 yrs. 6 mos. — ds.
(Signed) Wesley F. Orr M. D.
2/21 1920 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Ida | DATE OF BURIAL: 2-20 1920

20. UNDERTAKER: J. H. Mann | ADDRESS: Cottonwood

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

29111

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Idaho
City of Kenteroville
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)
File No. 10
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur J. Romain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 2 (Day) 1906 (Year)

7. AGE: 13 Yrs. 5 Mos. 17 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Romain

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Dorothea Winkler

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank G. Winkler
(Address) Cottonwood Ida

15. Filed July 21 1920 H. B. Blake Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1920 to July 19 1920
that I last saw him alive on July 19 1920.
and that death occurred on the date stated above, at 9:00 P.M.

The CAUSE OF DEATH* was as follows:
Influenza-Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.
7/21 1920 (Address) Cottonwood, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kenteroville Idaho
DATE OF BURIAL: 7-21- 1920

20. UNDERTAKER: A. L. Nall
ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 11
Registered No. 29112

1. PLACE OF DEATH.

County of Ada
City or Town Idaho (Green Creek / Green Cr.) No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Anne M Lewis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 18½ (Day) 1858 (Year)

7. AGE: 61 Yrs. 9 Mos. 4 da.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper.
(b) General nature of industry, business, or establishment in which employed (or employer): Farming.

9. BIRTHPLACE (State or Country): Effingham Ills

10. NAME OF FATHER: Henry Wassmuth

11. BIRTHPLACE OF FATHER (State or Country): Posen Prussian Germany

12. MAIDEN NAME OF MOTHER: Maria Anna Hoffman

13. BIRTHPLACE OF MOTHER (State or Country): Vichta Oldenburg Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Francis E Ratcliff
(Address) Green Creek Ida Co.

15. Filed Feby 22 1920 H Hopper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1920, to Feb 22 1920, that I last saw her alive on 2/22 1920, and that death occured on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Gastric Carcinoma
(Duration) 2 Yrs. ..... mos. ..... da.
Contributory (Secondary) —
(Duration ..... yrs. ..... mos. ..... da.

(Signed) Wesley F. Ord M. D.
3/10 1920 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Green Creek Ida — DATE OF BURIAL: 2-25-1920

20. UNDERTAKER: A. H. Nau — ADDRESS: Cottonwood Ida

WRITE PLAINLY, with UNFADING INK. ALL BLANKS must be filled. PHYSICIANS N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. of OCCUPATION is very important. See instructions on back of certificate.

8-7733 - WEST BR., PTG. & BDG. 24688

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

File No. 12
Registered No. 29113
If death occured in a hospital, institution or camp, give its NAME instead of street and number. .....

2. FULL NAME Henry Ruxoll

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Mch 3 1920
(Month) (Day) (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many hrs. or ..... mins.? 2

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L W Ruxoll

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Anna Arazen

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret V Blake
(Address) Cottonwood Idaho

15.
Filed Mch 4 1920 H W Blake
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 3 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 3rd 1920, to Mch 3rd 1920, that I last saw him alive on Mch 3rd 1920 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H W Blake M. D.
3/3 1920 (Address) Cottonwood

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Ida — DATE OF BURIAL: Mch 5 1920

20. UNDERTAKER: A. L. Nash — ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 105

County of Idaho

Primary Registration District No. 2183

City of Kenteroville (No. ....., ... St.)

File No. 13

Registered No. 29114

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Romain

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: August (Month) 29th (Day) 1878 (Year)

7. AGE: 41 yrs. 6 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinists
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Frank Romain

11. BIRTHPLACE OF FATHER (State or Country): Alsace Lorraine

12. MAIDEN NAME OF MOTHER: Mary Baecher

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dominic Romain
(Address) Kenteroville Idaho.

15.
Filed March 7 1920 H B Blake
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1919, to March 7 1920, that I last saw him alive on March 4th 1920, and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Was recovering from Influenza Pneumonia

(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) H B Blake M. D.

March 8 1920 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kenteroville Ida

DATE OF BURIAL: March 9th 1920

20. UNDERTAKER: C. H. Mann.

ADDRESS: Cottonwood Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29115

Registered No. 79

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 10 8

Primary Registration District No. 2184

County of Idaho

City of Kootkia (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret L. Adamson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Nov (Month) 9 (Day) 1885 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: — Patterson

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: — Tomey

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Adamson
(Address) Stites - Idaho

15.
Filed Feb 2 1920 J M Verbeurkmans
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1919 to Feb 1 1920 that I last saw h.. alive on Jan 28 1920 and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia following Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Endocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Verbeurkmans M. D.

Feb 2 1920 (Address) Kootkia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Cemetery — DATE OF BURIAL: Feb 2 1920

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29116

Registered No. 80

1. PLACE OF DEATH.

County of Idaho

City of Kooskia

(No. ....., ... St.)

Registration District No 106

Primary Registration District No 2184

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leona Conner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 20 (Day) 1919 (Year)

7. AGE ..... Yrs. 2 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Assistant

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Cyrus Conner

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Elsie Lawrence

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. H. Laurence

(Address) Kooskia Idaho

15. Filed Feb 11 1920

J. M. Verbeck
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1920, to Feb 9 1920, that I last saw her alive on Feb 7 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature - 7 mos bby

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Verbeck M. D.

Feb 11 1920 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Cemetery Kooskia — DATE OF BURIAL: 2/11 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2911

Registered No. 81

1. PLACE OF DEATH.

County of Idaho

City of Elk City

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106

Primary Registration District No. 2184

2. FULL NAME James W. MacKinnon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Nov. (Month) 24 (Day) 1874 (Year)

7. AGE 45 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Miner
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER Charles MacKinnon

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Jane MacDougall

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Beth MacKinnon
(Address) 716 Merritt St. Oshkosh, Wis.

15. Filed Feb 17 1920 J M Herbert Knuth Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
No medical attendance -
Death due to Influenza,

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) J M Herbert Knuth M. D.

Feb 17 1920 (Address) Kamiah - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Oshkosh - Wisconsin | DATE OF BURIAL .....191...

20. UNDERTAKER C J Johnson | ADDRESS Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29118

Registered No. 82

1. PLACE OF DEATH.

County of Idaho

City of Stites

(No. ....., ... St.)

Registration District No. 106

Primary Registration District No. 2184

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robt Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 29 (Day) 1862 (Year)

7. AGE: 58 Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L F Roy & Walker
(Address) .....

15. Filed March 1 1920 J M Meberkuns Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920, to Feb 2 1920,
that I last saw h. im alive on Feb 1 1920,
and that death occured on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows:
Accumulated Chronic Bright's
Trauma following re-
covery from Pneumonia
(Duration) ? Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
(Duration ..... yrs. ..... mos. 7 ds.
(Signed) H W Wentworth M. D.
Feb 2 1920 (Address) Stites

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Stites
DATE OF BURIAL: Feb 3 1920

20. UNDERTAKER: .....
ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 29119
Registered No. 83

1. PLACE OF DEATH.
County of Idaho
City of Sutes
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tyre Hutchens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. May (Month) 17 (Day) 1846 (Year)

7. AGE: 73 Yrs. 9 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: ——

11. BIRTHPLACE OF FATHER (State or Country): ——

12. MAIDEN NAME OF MOTHER: ——

13. BIRTHPLACE OF MOTHER (State or Country): ——

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address) Sutes Idaho

15. Filed March 1 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1919, to Feb 8 1920, that I last saw him alive on Dec 5 1919, and that death occured on the date stated above, at 6 30 P M.

The CAUSE OF DEATH* was as follows:
Arterio sclerosis - and mitial regurgitation

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Wentworth M. D.
Feb 8 1920 (Address) Sutes

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sutes
DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 29120
Registered No. 84

1. PLACE OF DEATH.
County of Idaho
City of Stites
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lizzie Craig

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (If married, widowed or divorced, how long.): Married

6. DATE OF BIRTH. ..... (Month) ..... (Day) ..... (Year)

7. AGE: 83 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Isaac Wickham
(Address) Stites Idaho

15. Filed March 1 1920 — J M Weberdines — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
No attendance - unknown
how ill about a week - no
compiaint
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H W Wentworth M. D.
Feb 15 1920 (Address) Stites Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Cemetery Stites — DATE OF BURIAL: Feb 16 1920

20. UNDERTAKER: Geo Heman — ADDRESS: Kooskia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 29121
Registered No. 85

1. PLACE OF DEATH.
County of Idaho
City of Stites
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert George

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	Red	Single (Write word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 13 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Milton George

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Annie Matthews

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jesse Williams
(Address) Stites

15. Filed March 1 1920 J. M. Weber Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1919, to Feb 22 1920, that I last saw h. alive on Dec 18 1919 and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of lungs

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) 2 yrs. 4 mos. ..... ds.
(Signed) H. N. Wentworth M. D.
Mar 4 1920 (Address) Stites Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Stites Indian Cemetery — DATE OF BURIAL Feb 24 1920

20. UNDERTAKER Geo Dunaway — ADDRESS Stites Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 22853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho — Registration District No. 106 — File No. 29122

City of Kooskia — Primary Registration District No. 2184 — Registered No. 86

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Brodock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 64 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dan Lamarcy

(Address) Kooskia

15. Filed March 1 1920 — J. M. Weberkamp, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to Feb 28 1920, that I last saw h[illegible] alive on Feb 28 1920, and that death occured on the date stated above, at 8:15 a M.

The CAUSE OF DEATH* was as follows: Chronic Parenchymatous Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Weberkamp M. D.

March 1920 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clearwater — DATE OF BURIAL: 3/2/20 1920

20. UNDERTAKER: Geo. H. Tenney — ADDRESS: Kooskia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29124

Registered No.

Registration District No. 23

Primary Registration District No. 1017-2017

1. **PLACE OF DEATH**

County of Jerome

City of 8 3/4 Mi South Jerome (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Mabel Alfa Harper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. **DATE OF BIRTH** Oct. (Month) 2 (Day) 1891 (Year)

7. **AGE** 28 Yrs. 4 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Missouri

10. **NAME OF FATHER** J.C.Clayton

11. **BIRTHPLACE OF FATHER** (State or Country) Ohio

12. **MAIDEN NAME OF MOTHER** Daisy Freeman

13. **BIRTHPLACE OF MOTHER** (State or Country) Missouri

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Thomas. J. Harper

(Address) Haley, Idaho

15. Filed Mar 6 1920

E. D. Pyper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb. (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3 1921, to Feb. 13 1920 that I last saw h.. alive on Feb. 13 1920 7:25 P.M. and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia following influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas F. Zeller M. D.

19..... (Address) Jerome, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome.	Feb, 15 19 20
20. UNDERTAKER D.A. L'Herisson	**ADDRESS** Jerome, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1017-2017
File No. 23125
Registered No.

1. PLACE OF DEATH

County of Jerome
City of Hazelton (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daisy Ethelyn Harper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Sept (Month) 3 (Day) 1916 (Year)

7. AGE: 3 Yrs. 5 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Harper

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mable Clayton

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Harper
(Address) Hailey Idaho

15. Filed Mar 6 1920 E. D. Piper
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 3 1920, to Feb. 12 1920 that I last saw h[illegible] alive on Feb. 12 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia following
influenza
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Zeller M. D.
19..... (Address) Jerome Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetery — DATE OF BURIAL: 2-14-1920

20. UNDERTAKER: D. R. Hermann — ADDRESS: Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Jerome

City of Jerome

Registration District No. 23

Primary Registration District No. 1017-2017

(No. ....., ... St.)

File No. 29126

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Opal Heuer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 16 (Day) 1900 (Year)

7. AGE: 20 Yrs. 5 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Michigan

10. NAME OF FATHER ~~Michigan~~ Archie Bragg

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Phebie M. Friedt

13. BIRTHPLACE OF MOTHER (State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Phebie M. Bragg
(Address) Jerome Ida

15. Filed Feb. 18 1920 E. D. Piper Local Registrar

BYRNE - YORK CO., PTRS. & BOOKB. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920, to Feb. 17 1920, that I last saw h[illegible] alive on Feb. 17 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
following Influenza

.....(Duration) .....Yrs. .....mos. 5 ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Chas. F. Zeller M. D.

.....19..... (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome Ida. DATE OF BURIAL: 2/19 1920

20. UNDERTAKER: D. A. L'Heureux ADDRESS: Jerome

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1017-2017
File No. 23127
Registered No.

1. PLACE OF DEATH
County of Jerome
City of Jerome
(No. ....., ... St.)
If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME Walter Coup

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH
Dec (Month) 30 (Day) 1919 (Year)

7. AGE
Yrs. 1 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER C. Ed. Coup

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Ada Shimmin

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. Shimmin
(Address) Jerome Idaho

15.
Filed 3/6 1920 E. D. Piper
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1919 to Feb 13 1920, that I last saw h.. alive on Feb 12 1920, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth.
weakling

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E D Piper M. D.
3/6 1920 (Address) Jerome

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome Ida	Feb 13 1920
20. UNDERTAKER	ADDRESS
D. A. L'Heureux	Jerome

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai Benewah
City of Worley Ida. (No. ....., ... St.)
Registration District No. 46
Primary Registration District No. 2153
File No. 29128
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mildred Lee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH. July (Month) 18 (Day) 1919 (Year)

7. AGE Yrs. 6 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Worley, Idaho

10. NAME OF FATHER Geo Lee

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Ina Beguedreau

13. BIRTHPLACE OF MOTHER (State or Country) South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George Lee
(Address) Worley, Ida.

15. Filed Feb 20 1920 H. Jaques Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February 17 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 17 1920, to Feb 17 1920 that I last saw her alive on Feby 17 1920 and that death occured on the date stated above, at 10-15 P.M.

The CAUSE OF DEATH* was as follows:
Spanish Influenza

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Teething
(Duration yrs. 2 mos. ds.
(Signed) H. C. Dickies M. D.
19.... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Worley, Ida.	Feb. 11 1920
20. UNDERTAKER None	ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 46

Primary Registration District No. 2123

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29129

Registered No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Worley Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alta Eurietha Jones.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. Nov (Month) 27th (Day) 1899 (Year)

7. AGE: 20 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Girl.

(b) General nature of industry, business, or establishment in which employed (or employer)... General House Work.

9. BIRTHPLACE (State or Country) Huntley, Nebraska.

10. NAME OF FATHER Charles H. Jones.

11. BIRTHPLACE OF FATHER (State or Country) Harrison Co. Missouri.

12. MAIDEN NAME OF MOTHER Eurietha Danskin.

13. BIRTHPLACE OF MOTHER (State or Country) Iowa Co. Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Feb. 15 1920

H. G. Jagers
Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8th 1920, to Feb 12th 1920, that I last saw her alive on Feb 12th 1920, and that death occured on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:

Pneumonia Following Influenza.

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) ✓ (Duration) ✓ yrs. ✓ mos. ✓ ds.

(Signed) S. C. Harrington M.D.

2/14 1920 (Address) Plummer Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Worley, Idaho.

DATE OF BURIAL: 2/14/1920

20. UNDERTAKER: H. G. Jagers

ADDRESS: Plummer Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 1050
File No. 23180
Registered No. 680

1. PLACE OF DEATH
County of Kootenai
City of ——
(No. Wolf Lodge St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Adam Nissenback

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Feb (Month) 10 (Day) 1 (Year)

7. AGE: 82 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Nissenback
(Address) Coeur d Alene Ida

15. Filed Jan 10 1920 D D Greenwood Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7 1920 to Jan 9 1920
that I saw h... alive on ... 19...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Senile decay

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary): Dropsy
(Duration) ... yrs. 6 mos. ... ds.

(Signed) D D Greenwood M. D.
1/9 1920 (Address) Coeur d Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State 19 yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 1-11 1920

20. UNDERTAKER: [illegible] — ADDRESS: C d A Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29131
Registered No. 692

1. PLACE OF DEATH.
County of Kootenai
City of ..... (No. ....., ... St.)

Registration District No. 30
Primary Registration District No. 1061

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Osmar William Costin

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH February (Month) 2 (Day) 1920 (Year)

7. AGE ..... yrs. ..... mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kootenai County

10. NAME OF FATHER Frank Costin

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Kathyleen Hauer

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Costin
(Address) Coeur d'Alene Ida

15.
Filed 3-10 1920 D. D. Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH February (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Child was dead when I arrive. Conditions indicate child died of aspiration pneumonia
(Duration) ..... yrs. ..... mos. One ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Louis H. Most M. D.
Feby 13 1920 (Address) Coeur d'Alene, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. 10 ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Gladson Mining Co. DATE OF BURIAL Feb 14 1920

20. UNDERTAKER [illegible] ADDRESS C d A Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1951
File No. 29132
Registered No. 69

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 615 Lake Shore Drive St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Henry Freedlander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Nov (Month) 19 (Day) 1 (Year)

7. AGE: 45 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Manager Cd'a
(b) General nature of industry, business or establishment in which employed (or employer): Lumber Co

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: William Henry Freedlander

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mary Blay

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Alice Freedlander
(Address) Coeur d'Alene Ida

15. Filed 2-10 1920 D. D. Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1920 to Feb 8 1920
that I last saw h[e] alive on Feb 8 1920,
and that death occurred on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 5 ds.

(Signed) J. C. Bayne M. D.
1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State K yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Cremation

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn — DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER: [illegible] Rooney — ADDRESS: C d'A Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 23135
Registered No. 690

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. C d A T Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Blair Sebring

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Jan. (Month) 30 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Blair Sebring

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Alice Coss

13. BIRTHPLACE OF MOTHER (State or Country) Miss

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Blair Sebring
(Address) Coeur d'Alene Idaho

15. Filed 3-10 1920 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Feb~~ Jan. 30 1920, to Feb. 6 1920, that I last saw h~~im~~ alive on Feb. 6 1920, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Exhaustion following Colostomy

(Duration) ... Yrs. ... mos. 7 ds.
Contributory (Secondary) Congenital atresia of colon.
(Duration) ... yrs. ... mos. 7 ds.

(Signed) John O Wood M. D.
Feb. 7 1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	Feb 9th 1920

20. UNDERTAKER R E Mooney — ADDRESS C d A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 90
County of ____ Primary Registration District No. 2057
City of Athol (No. Athol Idaho St.)
File No. 29134
Registered No. 689

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Elizabeth White

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Widowed
6. DATE OF BIRTH: Sept - 7-1840 (Month) (Day) (Year)
7. AGE: 79 yrs. 4 mos. 17 ds. IF LESS than 1 day how many ..... *hrs.* or ..... *min.*?
8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Indiana
10. NAME OF FATHER: Jacob Padgett
11. BIRTHPLACE OF FATHER (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Hannah Sisson
13. BIRTHPLACE OF MOTHER (State or Country): Indiana
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G H White
(Address) Yakima Washington
15. Filed 2/25 1920 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 24, 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feby 22 1920 to ____ 191 ____ that I last saw h[illegible] alive on Feby 22 1920 and that death occurred on the date stated above, at 1.10 P. M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ____ yrs. ____ mos. 14 ds.
Contributory (Secondary) Influenza
(Duration) ____ yrs. ____ mos. 7 ds.
(Signed) George T. Penn M. D.
Feby 25 1920 (Address) E 20 8 Sprague

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane. Washington
DATE OF BURIAL: Feb 26- 191

20. UNDERTAKER: Turnbull Co
ADDRESS: Spokane

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Post Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 2031

(No. ..... St.)

File No. 23135

Registered No. 688

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorthy Teters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 21 (Day) 19 (Year)

7. AGE: 4 Yrs. 5 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C a Teters

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Tatona Chute

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C a Teters

(Address) Post Falls Ida

15. Filed 3-10 1920 D D Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5 1920 to Feb 16 1920 that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

X Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. L. McCauley M. D.

2/16 1920 (Address) Post Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 4 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls | DATE OF BURIAL: 2-17 1920

20. UNDERTAKER: R B Mooney | ADDRESS: C d'A Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1857
File No. 29136
Registered No. 693

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. Atlas Lie Flat St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Melvin Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1920 (Year)

7. AGE: ____ Yrs. ____ Mos. ____ ds.
IF LESS than 1 day how many 3 hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ____
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Melvin Phillips

11. BIRTHPLACE OF FATHER (State or Country): So Dak

12. MAIDEN NAME OF MOTHER: Mary Marshall

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Melvin Phillips
(Address) Coeur d'Alene Ida

15.
Filed 3-10 1920 D D Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1920, to Feb 19 1920, that I last saw h[er] alive on Feb 19 1920, and that death occurred on the date stated above, at 4 40 P M.

The CAUSE OF DEATH* was as follows:
Premature Birth
3 hours
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Pulmonary Hemorrhage
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) L. W. Thurston M. D.
Feb 20 1920 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Feb 21 1920

20. UNDERTAKER: [illegible] — ADDRESS: Cda Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 29137
Registered No. 694

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thelma Elizabeth Robinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Coeur d'Alene Ida

10. NAME OF FATHER: M. M. Robinson

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Prichett

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. M. Robinson
(Address) 608 S. 12th St

15. Filed 3-10 1920 D. D. Drennan, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19..., to ——— 19..., that I last saw h... alive on ——— 19..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Was dead when I made call Probably suffocated from phlegm Child 12 cold.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) D. D. Drennan M. D.
19... (Address) ...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 2-27 1920

20. UNDERTAKER: [illegible] Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 20138
Registered No. 695

1. PLACE OF DEATH
County of Kootenai Registration District No. 90
Primary Registration District No. 1051
City of Coeur d'Alene (No. 621 Indiana St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Bell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Mch (Month) 22 (Day) 1839 (Year)

7. AGE: 80 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: John Bell

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Ann Atherton

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M J Bell
(Address) Ashland Wis

15. Filed 3-10 1920 D D Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1920, to Feb. 27 1920, that I last saw h.. alive on Feb 26 1920, and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. 5 ds.
Contributory (Secondary) Arteriosclerosis, Chronic
Lent Lesion (Duration) yrs. mos. ds.

(Signed) J O Dwyer M. D.
19..... (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs. 2 mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Superior Wis
DATE OF BURIAL 19.....
20. UNDERTAKER: R B Mooney
ADDRESS Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1951
File No. 25139
Registered No. 696

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. Emergency Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Perryman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 17 (Day) 1 (Year)

7. AGE: 13 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: F L Perryman

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Lida A Dawson

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): F L Perryman
(Address): Coeur d'Alene

15. Filed 3-10 1920 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1920, to July 29 1920 that I last saw h. alive on July 29 1920 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

"Flu"

(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) D. D. Drennan M. D.

3/2/1920 (Address) D. D. Drennan

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 20 days. In the State ..... yrs. 6 mos. 20 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Mch 2 1920

20. UNDERTAKER: H. C. Doody — ADDRESS: C d A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051 & 2057
(No. ....., ... St.)

File No. 129140
Registered No. 5

1. PLACE OF DEATH.
County. of Kootenai
City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Perry A. Bowers

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. May (Month) 14 (Day) 1919 (Year)

7. AGE: Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Anthon Bowers

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Mary Woolsey

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Anthon Bowers
(Address) Rathdrum Ida

15. Filed 2/20. 1920 Frank Wenz
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 16. 1920, to Feby 19. 1920, that I last saw h.im alive on Feby 18. 1920, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Bronchio - Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Epidemic Influenza

(Duration ..... yrs. ..... mos. 4 ds.

(Signed) Frank Wenz M. D.

2/20. 1920 (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Cemetery — DATE OF BURIAL: Feb. 20 1920

20. UNDERTAKER: O. W. Gideon — ADDRESS: Rathdrum Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30

Primary Registration District No. 1051 & 2051

File No. 125141

Registered No. 4

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pauline E. Bohn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 16 (Day) 1891 (Year)

7. AGE: 28 Yrs. 8 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Daniel Splittstosser

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Augusta Splittstosser

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Paul C. Bohn
(Address) Belmont Idaho

15. Filed Jany 20 1920 Frank O'Neil Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 10 1920, to Jany 18 1920, that I last saw her alive on Jany 10 1920, and that death occured on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Heart-Disease
Mitral insufficiency

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Frank O'Neil M. D.

1/19 1920 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Cemetery — DATE OF BURIAL: Jan 20 1920

20. UNDERTAKER: A. W. Storm — ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1650
File No. 20142
Registered No. 14

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Evans
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: April (Month) 13 (Day) 1853 (Year)

7. AGE: 36 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mill worker
(b) General nature of industry, business or establishment in which employed (or employer): Blackwell Lumber Co

9. BIRTHPLACE (State or Country): Mont.

10. NAME OF FATHER: William Evans

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Martha Sanphe

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Evans
(Address) Coeur d'Alene

15. Filed Feb. 27 1920 Gus Nelson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920, to Feb 23 1920, that I last saw h.im alive on Feb 23 1920, and that death occurred on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) 9 Yrs. ..... mos. 9 ds.

Contributory (Secondary) Endocarditis

(Duration) Mural Yrs. ..... mos. ..... ds.

(Signed) Alexander Barclay M. D.

2-23 1920 (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 0 yrs. 0 mos. 9 days. In the State 0 yrs. 6 mos. ..... days

Where was disease contracted if not at place of death? Coeur d Alene.

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 2/27 1920

20. UNDERTAKER: [illegible] — ADDRESS: Cda - Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29143

Registered No. 12

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

Registration District No. 21

Primary Registration District No. 1 or 2

(No. 818 3rd St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clifford Oscar Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Jan (Month) 19 (Day) 1904 (Year)

7. AGE: 16 Yrs. 1 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... s.c. Scaler

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Gus Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Matilda Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gust Olson

(Address) 707 3rd St. C D'Alene

15. Filed Feb 25 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 22 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19, 1920, to Feb. 22 1920, that I last saw h[im] alive on Feb 22 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) 0 Yrs. mos. 4 ds.

Contributory (Secondary) Influenza

(Duration) 0 yrs. mos. 6 ds.

(Signed) J. C. Berry M. D.

19 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Coeur d'Alene — DATE OF BURIAL: 2-25-1920

20. UNDERTAKER: C Cassedy — ADDRESS: D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29 [illegible]
Primary Registration District No. 1057
File No. 29144
Registered No. 11

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene R.F.D. #1 (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Almira Beatty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Oct. (Month) 18 (Day) 1864 (Year)
7. AGE: 55 Yrs. 4 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ill.
10. NAME OF FATHER: —
11. BIRTHPLACE OF FATHER (State or Country): —
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) [illegible] to Beatty
(Address) Coeur D' Alene
15. Filed Feb 25 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 23 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 23 1920, to ..... 1920, that I last saw h..... alive on July 23 1920, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Flu
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. D. Dr[illegible] M. D.
7/25 1920 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene — DATE OF BURIAL: 2-26 1920
20. UNDERTAKER: C. Cassedy — ADDRESS: C. D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29145

Registered No. 10

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene (No. 707 Front St.)

Registration District No. 29

Primary Registration District No. 1050

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie A. Bunting

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Sept 21 1865
(Month) (Day) (Year)

7. AGE: 54 Yrs. 5 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ——
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Victoria, B. C.

10. NAME OF FATHER: Stephen Perow Bunting

11. BIRTHPLACE OF FATHER (State or Country): N. B.

12. MAIDEN NAME OF MOTHER: ——

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Leopold Bunting
(Address) 707 Front Ave C d'A I

15. Filed Feb 23 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 21 1920, to Feby 22 1920, that I last saw h[im] alive on Feby 22 1920, and that death occured on the date stated above, at 7:20 P M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Epileptic Physician
Mitral Insufficiency
(Duration 41 yrs. — mos. — ds.

(Signed) C. E. Hutchings M. D.
19..... (Address) Coeur d'alene Id
6th Sherman Ave

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. Coeur d'Alene — DATE OF BURIAL: Feb 24 1920

20. UNDERTAKER: [redacted] — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29146
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
(No. R. F. D. #2 St.)
Registration District No. 49
Primary Registration District No. 1058
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Henry Bloomster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W.	Single

6. DATE OF BIRTH. June (Month) 10 (Day) 1917 (Year)

7. AGE 2 Yrs. 8 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Minn

10. NAME OF FATHER Albert M. Bloomster

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Myra Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Myra Bloomster
(Address) .....

15. Filed Feb 23 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 21 1920, to Feb. 21 1920, that I last saw him alive on Feb. 21 1920 and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Shock from Severe Scald.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) John Wood M. D.
Feb. 23 1920 (Address) Coeur d'Alene, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetary	Feb. 23 1920
20. UNDERTAKER C Cassedy	ADDRESS C d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2947

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 24

Primary Registration District No. 1052

County of Kootenai

City of Coeur d'Alene (No. 822, Mullan St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Kaufman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) 9 (Day) 20 (Year) 1870

7. AGE: 49 Yrs. 4 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Lineman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mich

10. NAME OF FATHER Daniel Kaufman

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Emily Brown

13. BIRTHPLACE OF MOTHER (State or Country) Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Julia Hayek
(Address) Coeur D'Alene Idaho

15. Filed Feb 8 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) July (Day) 6" 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920, to ——— 191..., that I last saw him alive on 2/1 1920, and that death occured on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ——— mos. ——— ds.

(Signed) O. E. Montanyne M. D.

2/8 1920 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. C'Dalene — DATE OF BURIAL: 2-8 1920

20. UNDERTAKER: C. Cassedy — ADDRESS: Coeur d'Alene

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1650
(No. ....., ... St.)

File No. 23148
Registered No. 6

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys I. Schwarzbach

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Feb. (Month) 5 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER W^m Schwarzbach

11. BIRTHPLACE OF FATHER (State or Country) Wis

12. MAIDEN NAME OF MOTHER Olive Pyle

13. BIRTHPLACE OF MOTHER (State or Country) Mont-

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed Feb. 14 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 5 1920, to Feb. 13. 1920, that I last saw h[illegible] alive on Feb. 13. 1920, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Acute Gastro-Enteritis.

..... (Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos O'Connell M. D.
Feb. 14 1920 (Address) Coeur d'Alene. Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	2-14 1920
20. UNDERTAKER C. Cassedy	ADDRESS C'Dalene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29149

Registered No. 7

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene (No. 206 Garden Ave St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 1050

2. FULL NAME Lida May Sheely

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	W.	married

6. DATE OF BIRTH. June (Month) 18 (Day) 1886 (Year)

7. AGE 23 Yrs. 8 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Florida

10. NAME OF FATHER C. E. Tucker

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER — Fowler

13. BIRTHPLACE OF MOTHER (State or Country) Florida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. J. Sheely
(Address) 206 Garden Ave

15. Filed Feb. 19 1920 Geo Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-12- 1920, to 2-18- 1920, that I last saw her alive on Feb 16 - 1920, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia following influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Alexander Sarelas M. D.

2-19 1920. (Address) C. D'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL Great Falls Mont. DATE OF BURIAL 1920

20. UNDERTAKER C. Cassedy. ADDRESS Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S/ No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 46

Primary Registration District No.

File No. 29150

County of Kootenai

City of Spirit Lake (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Samuel R. Richardson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 20 (Day) 1858 (Year)

7. AGE: 61 Yrs. 4 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Millwright

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber mill

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Hugh Richardson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Margaret Ray

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Doris Johnson

(Address) Hoquiam Wash.

15. Filed 2/1 1920. Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1919, to Jan 27 1920, that I last saw him alive on Jan 27 1920, and that death occured on the date stated above, at 4:30 P M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Several Yrs. — mos. — ds.

Contributory (Secondary) Arterio Sclerosis

(Duration) Several yrs. — mos. — ds.

(Signed) Earle A Pringle M. D.

2-11 1920 (Address) Spirit Lake Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spirit Lake Feb | DATE OF BURIAL: 1920

20. UNDERTAKER: O W Gibson | ADDRESS: Rathdrum Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29151

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
(No. ....., ... St.)

File No. 2
Registered No. 53

1. PLACE OF DEATH.

County of Kootenai
City of Dudley Idaho

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Squire Byrne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	married

6. DATE OF BIRTH.
April (Month) 21 (Day) 1844 (Year)

7. AGE
..... Yrs. 75 Mos. 9 ds. 10
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Preston Co. West Va.

10. NAME OF FATHER Samuel Byrne.

11. BIRTHPLACE OF FATHER
(State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Fernandez Hagans.

13. BIRTHPLACE OF MOTHER
(State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Earl Joseph Byrne.
(Address) Dudley, Idaho.

15.
Filed Mar 1 1920 J. R. Cumming
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920, to Feb 1 1920, that I last saw him alive on Feb 1st 1920, and that death occured on the date stated above, at 4A M.

The CAUSE OF DEATH* was as follows:
Chronic endocarditis

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Senility
..... (Duration 2 yrs. mos. ..... ds.
(Signed) L. J. Stauffer M.D.
3-1 1920 (Address) Rose Lake, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rose Lake, Idaho.	191

20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29152

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

Registration District No. 126

Primary Registration District No. 2204

(No. .... St.)

File No. 2

Registered No. 54

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1920 (Year)

7. AGE ....Yrs....Mos....ds.

IF LESS than 1 day how many 3 hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER J B. Manifold

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Grace K. Conselius

13. BIRTHPLACE OF MOTHER (State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J B. Manifold

(Address) Harrison

15. Filed Mar 1 1920 J M Fleming Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1920, to Feb 18 1920, that I last saw h.. alive on Feb 18 1920, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

7 mo Stillborn

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

(Duration ....yrs....mos....ds.

(Signed) J M Fleming M. D.

2-7 1920 (Address) Harrison

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Harrison — DATE OF BURIAL: 2-21 1920

20. UNDERTAKER Owen — ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29153 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2-204
(No. ..... St.)

File No. 2
Registered No. 53

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai
City of Spangsboro
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mike Demerra

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Sept (Month) ... (Day) 1879 (Year)

7. AGE 71 Yrs. 6 Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Corn Sober.
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER Antony

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Mariana

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Dimico
(Address) Spangsboro

15. Filed Mar. 1 1920 J. McKenney Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191...,
that I last saw h... alive on ... 191...,
and that death occured on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Senility

... (Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) ...
... (Duration) ... yrs. ... mos. ... ds.
(Signed) J. McKenney M. D.
2-19 1920 (Address) Harrison

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL Harrison — **DATE OF BURIAL** 2-21 1920

20. UNDERTAKER Moore — **ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B. In pla

Filed ... 19...
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

20. UNDERTAKER Ellen Grace — ADDRESS Moscow

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29153 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2-204
(No. ..... St.)

File No. 2
Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of Spangsbon

2. FULL NAME Mike Demerra

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) ..... (Day) 1879 (Year)

7. AGE: 71 Yrs. 6 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Com Labor
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Antony

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Maria

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nello Dimico
(Address) Spangsbon

15. Filed Mar. 1 1920 J. McKenney Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Senility
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. McKenney M. D.
2-19 1920 (Address) Spangsbon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spangsbon | DATE OF BURIAL: 2-21 1920

20. UNDERTAKER: Moore | ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 61 2915 4

Primary Registration District No. 10 11

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 77

1. **PLACE OF DEATH**

County of Latah

City of Moscow.

(No.) (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Mabel May Martinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	

6. **DATE OF BIRTH** February (Month) 1 (Day) 1920 (Year)

7. **AGE** ....Yrs. ....Mos. 2 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Moscow. Idaho

10. **NAME OF FATHER** Mandell Martinson

11. **BIRTHPLACE OF FATHER** (State or Country) LaCrosse Wisconsin

12. **MAIDEN NAME OF MOTHER** Elsew Gruffith

13. **BIRTHPLACE OF MOTHER** (State or Country) Pullman. Wash

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mandell P. Martinson

(Address) Moscow. Idaho.

15. Filed Feb. 6 1920 N H Carruthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** February (Month) 3 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Feb 1 1920, to Feb. 3 1920 **that I last saw him alive on** Feb. 2 1920 **and that death occurred on the date stated above, at** ....M.

The CAUSE OF DEATH* was as follows:

Prematurity - due to
Influenza of Mother

.... (Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)

.... (Duration) .... yrs. .... mos. .... ds.

(Signed) Virgil M. Gilchrist M. D.

Feb 3 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. 2 days. In the State .... yrs. .... mos. 2 days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Moscow — **DATE OF BURIAL** 2/4 1920

20. **UNDERTAKER** Allen Bruce — **ADDRESS** Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 29155
Registered No. 78

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Ann Briggs
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: March 30 (Month) (Day) 1843 (Year)

7. AGE: 76 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Anson Richmond

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sarah Jacobus.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Sadie B. Hunter
(Address) .....

15. Filed Feb. 17th 1920 — W. J. Carithers, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Jan~~ Feb. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16 1920, to Feb 16th 1920 that I last saw h.. alive on Feb 16th 1920 and that death occurred on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Arteria Sclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Stevenson M. D.
Feb 17 1920 (Address) Moscow Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Corvallis, Oregon — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Sirkel — ADDRESS: Moscow Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 23150
Registered No. 85

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa C Callison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Aug (Month) 1 (Day) 1855 (Year)

7. AGE: 64 Yrs. 6 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: James J. Rush

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Margaret Mahoney

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. I. Callison
(Address):

15. Filed. Feb 29 1920 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 17 1920 to Feby 29 1920 that I last saw h.. alive on Feby 29 - 1920 and that death occurred on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Charles L. Gibbons M. D.
[redacted] 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 13 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Kendrick, Ida.
Former or usual residence Kendrick Idaho

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: March 2 1920

20. UNDERTAKER: Glen Price
ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... , ... St.)
File No. 29157
Registered No. 86

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorthy Ethel Foote

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Dec (Month) 23 (Day) 1919 (Year)

7. AGE: Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Canada,

10. NAME OF FATHER: James E. Foote.

11. BIRTHPLACE OF FATHER (State or Country): North Dakota

12. MAIDEN NAME OF MOTHER: Ethel Turner.

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James E. Foote.
(Address) Moscow Idaho

15. Filed Feb 17th 1920 N H Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not attend deceased 19..... to 19.....
that I last saw h..... alive on Feb. 16 1920
and that death occurred on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:
Malnutrition

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Clarke M. D.
Feb 17 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Feb 18 1920

20. UNDERTAKER: Gill Bros | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 29158
Registered No. 85

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hester Hannah Meining
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 20 (Day) 1891 (Year)

7. AGE: 28 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Charles Coulton

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Effie French

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Meining
(Address) Moscow Idaho

15. Filed Feb 8 1920 N. H. Carruthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 25 1920, to Feb. 6 1920, that I last saw h.r alive on Feb. 7 1920 and that death occurred on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Clarke M. D.
2/8 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. DATE OF BURIAL: Feb 9 1920

20. UNDERTAKER: Tilden Rice ADDRESS: Moscow Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. ..... St.)

File No. 29159

Registered No. 82

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Grecar.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: S (Write the word.)

6. DATE OF BIRTH: Aug (Month) 14 (Day) 1914 (Year)

7. AGE: 5 Yrs. 5 Mos. ds. 21

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER James P. Grecar.

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Nettie Rice.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James P. Greer.

(Address) Moscow

15. Filed Feb 5 1920 W. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 22" 1920, to Feb. 4" 1920, that I last saw him alive on Feb. 4" 1920, and that death occurred on the date stated above, at 1130 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Carithers M. D.

2/5 1920 (Address) Moscow, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Feb 6 1920

20. UNDERTAKER: Glen Price | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 29160
Registered No. 84

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse Horace Warley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 9 (Day) 1891 (Year)

7. AGE: 29 Yrs. ..... Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Grant Warley.

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Helen Surratt

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. H. Warley
(Address) .....

15. Filed Feb 9th 1920 W. H. Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 CT 1920 to Feb. 7 CT 1920 that I last saw h[illegible] alive on Feb 7 1920 and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 7 ds.
(Signed) F. W. Fleer M. D.
2/9 1920 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Feb 9th 1920

20. UNDERTAKER: Glenn Price — ADDRESS: Moscow

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 29161
Registered No. 83

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Duffy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	W.	Married

6. DATE OF BIRTH: Aug (Month) 13 (Day) 1885 (Year)

7. AGE: 34 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Enos Byers

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sarah A. Stephenson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Wm. P. Smith
(Address) Elk River, Ida.

15. Filed Feb 8 1920 N.H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920 to Feb 5 1920 that I last saw her alive on Feb 5 1920 and that death occurred on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:
Influenza Pneumonia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Cedar M. D.
2/8 1920 (Address) Moscow Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Centralia Wash
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Glen Price
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Adair

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ....., ... St.)
File No. 29102
Registered No. 81

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loudiska C. Buchanan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: March (Month) 27 (Day) 1840 (Year)

7. AGE: 79 Yrs. 10 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Henry M Collins

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Mary Caswell Kenberg

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Henry McGregor
(Address) Moscow Idaho

15. Filed Feb 4 1920 W H Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1919 to Jan 1920 that I last saw her alive on Jan 1919 and that death occurred on the date stated above, at 2 30 M.

The CAUSE OF DEATH* was as follows:
Tuberculosis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W A Adam M. D.
2/4 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 2/4 1920

20. UNDERTAKER: Allen Price | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Latah

CERTIFICATE OF DEATH

61

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1011
(No. ..... St.)

File No. 29163
Registered No. 80
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha M. West.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH: Sept (Month) 15 (Day) 1885 (Year)

7. AGE: 34 Yrs. 4 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: E. J. Gratebner

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. C. West
(Address) Moscow

15. Filed Feb 3 1920 N H Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1920 to Feb. 2 1920 that I last saw her alive on Feb. 2 1920 and that death occurred on the date stated above, at 430 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.

2/3 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 2/4 1920

20. UNDERTAKER: Allen Price | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 29164
Registered No. 79

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John H. Rich.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 8 (Day) 1888 (Year)

7. AGE: 31 Yrs. 6 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Educator
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jonesville, Iowa

10. NAME OF FATHER: Edward H. Rich

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Elizabeth Jennings

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nellie Virginia Rich
(Address) Moscow, Idaho

15. Filed Feb 1 1920 N. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 31 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1920 to Jan 31 1920
that I last saw h[illegible] alive on Jan. 31 1920
and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Fortman M. D.

2/1 1920 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Feb 3 1920

20. UNDERTAKER: Glen Sies | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29165

Registered No. 2

1. PLACE OF DEATH.

County of Lemhi

City of Gneseo

Registration District No.

Primary Registration District No. 2142

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Meyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. June 21 1870 (Month) (Day) (Year)

7. AGE 49 Yrs. 7 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER C A Meyer

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Catherine Bullwinkle

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Meyer
(Address) Genesee Idaho

15. Filed 2-6 1920 W E Eheen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby 6 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920, to Feby 5 1920, that I last saw h— alive on Feb 5 1920, and that death occured on the date stated above, at 8 am M.

The CAUSE OF DEATH* was as follows:

Divine Healers and Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Influenza

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W E Eheen M. D.

2-6 1920 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Genesee Idaho — DATE OF BURIAL 2-8 1920

20. UNDERTAKER J E Lambert — ADDRESS Genesee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah — Registration District No. 62

City of Genesee — Primary Registration District No. 2142

(No. ..... St.)

File No. 29166

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Sarah Anna Davis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. February 7th 1845 (Month) (Day) (Year)

7. AGE: 75 Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: first name not known Traffal

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. H. Wheeler

(Address) Genesee Ida.

15. Filed Feb 16 1920 — W. N. Elsom, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13 1919, to Nov. 24 1919, that I last saw h alive on Nov 24th 1919, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Chronic Nephritis

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) W. F. Eberle M. D.

2-7 1920 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee — DATE OF BURIAL: 2-16 1920

20. UNDERTAKER: F. E. Lambert — ADDRESS: Genesee Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, FULL, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Items, especially of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2142
File No. 29167
Registered No. 4

1. PLACE OF DEATH.
County of Nez Perce
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A Gibb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Jan. (Month) 26 (Day) 1885 (Year)

7. AGE: 35 Yrs. 0 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Grain Farmer

9. BIRTHPLACE (State or Country): Latah Co. Idaho

10. NAME OF FATHER: Wm. Napier Gibb

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary M. Gibb
(Address) Genesee Idaho

15.
Filed 2-21 1920
W. H. Cohen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 17th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11 1920 to Feb 17 1920, that I last saw h alive on Feb 17th 1920 and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C L Gutierson M. D.
2-20 1920 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 2-22 1920

20. UNDERTAKER: J. E. Lambert
ADDRESS: Genesee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24665

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6
Primary Registration District No. 2162
File No. 29168
Registered No. 5

1. PLACE OF DEATH.
County of Nolding
City of Lewiston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Jamison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Cauc	Married

6. DATE OF BIRTH: Dec (Month) 28 (Day) 1849 (Year)

7. AGE: 70 yrs. 1 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Block Smith
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Geo Jamison

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Webster Jamison
(Address) Lewiston Idaho

15.
Filed 2-28 1920 W. H. Coleman Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1920 to Feb 26 1920 that I last saw h~~im~~alive on Feb 26 1920 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris.

(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Asteno-Neurosis
(Duration) 10 yrs. ..... mos. ..... ds.
(Signed) E. L. White M. D.
Feb 27 1920 (Address) Lewiston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Genesee Idaho	2-28 1920

20. UNDERTAKER	ADDRESS
J. E. Lambert	Genesee Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
(No. ..... St.)

File No. 29169
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. **PLACE OF DEATH**
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Anna Bird Byers.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.) Single

6. **DATE OF BIRTH** Aug 31 (Month) (Day) 1900 (Year)

7. **AGE** Yrs. 19 Mos. 5 ds. 14
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Pullman Wash.

10. **NAME OF FATHER** Ephraim Byers

11. **BIRTHPLACE OF FATHER** (State or Country) Iowa

12. **MAIDEN NAME OF MOTHER** Anna C. Carter

13. **BIRTHPLACE OF MOTHER** (State or Country) Iowa

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) C. H. Byers
(Address) Troy Idaho

15. Filed Feb 14 1920 J. E. Packard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb (Month) 14 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Feb. 11 1920 to Feb 14 1920 that I last saw her alive on Feb. 11 1920 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) 4 Yrs. ..... mos. 11 ds.
Contributory (Secondary) Influenza
(Duration) — yrs. ..... mos. 11 ds.

(Signed) C K Hinkle M. D.
2/14 1920 (Address) Troy Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Burial — **DATE OF BURIAL** Feb 12 1920

20. **UNDERTAKER** J E Packard — **ADDRESS** Troy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 29170
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Troy (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christine Alice Payne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: March (Month) 19 (Day) 1845 (Year)

7. AGE: 74 yrs. 10 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Hezekiah Townsend

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah Richards

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daisey M. Strong
(Address) Troy

15.
Filed Feb 9 1920 J E Pickerd Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Feb 1919 to 1919, to Feb 2, 1920 that I last saw h[illegible] alive on 2-2 1920 and that death occurred on the date stated above, at 3:15 P. M.

The CAUSE OF DEATH* was as follows:
Insipit Tuberculosis

(Duration) 7 yrs. 8 mos. — ds.
Contributory (Secondary) Auto exertion
(Duration) yrs. mos. ds.

(Signed) C K Hemkle M. D.
2-9 1920 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge — DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER: J E Pickerd — ADDRESS: Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 2317
Registered No.

1. PLACE OF DEATH

County of Latah
City of Troy
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charley H Robertson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Feby (Month) 3rd (Day) 1885 (Year)

7. AGE: 35 Yrs. Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: RR Section Foreman
(b) General nature of industry, business or establishment in which employed (or employer): Railroad

9. BIRTHPLACE: Hartford Kansas (State or Country)

10. NAME OF FATHER: Lewis Hamlin Robertson

11. BIRTHPLACE OF FATHER: Arkansas (State or Country)

12. MAIDEN NAME OF MOTHER: Sarah DeMoss

13. BIRTHPLACE OF MOTHER: Kansas (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Robertson
(Address) Troy Idaho

15. Filed Feb 17 1920 — J E Pickerd, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 16th (Month) 1920 (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 31. 1920, to Feb 16 1920, that I last saw him alive on Feb 16. 1920, and that death occurred on the date stated above, at 7.15 P M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ... Yrs. ... mos. 18 ds.
Contributory (Secondary) Paralitis & Influenza.
(Duration) — yrs. ... mos. 19 ds.

(Signed) C K Hankle M. D.
2-17 1920 (Address) Pray Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mondovi — DATE OF BURIAL: 2-22 1920

20. UNDERTAKER: J E Pickerd — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
File No. 29173

1. PLACE OF DEATH.
County of Latah
City of Princeton (No. ..... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ellen Warfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. Sept (Month) 14 (Day) 1845 (Year)
7. AGE: 75 Yrs. 5 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: Bragg
11. BIRTHPLACE OF FATHER (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: White
13. BIRTHPLACE OF MOTHER (State or Country): Virginia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Arthur Warfield
(Address) Princeton Idaho
15. Filed Feb 28th 1920 D. Jr. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 26 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1920 to Feb 24 1920, that I last saw h[illegible] alive on Feb 24 1920, and that death occured on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Influenza
(Duration) — Yrs. — mos. 4 ds.
Contributory (Secondary) none
(Duration — yrs. — mos. — ds.
(Signed) E. K. Wolfe M. D.
2/28 1920 (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Johnson Cem. DATE OF BURIAL: Mar 2 1920
20. UNDERTAKER: E. Mason ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29174

Registered No. .....

Registration District No. 65

Primary Registration District No. 2145

1. PLACE OF DEATH.

County of Latah

City of Palouse

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Srnec

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 27 (Day) 1871 (Year)

7. AGE: 49 Yrs. ..... Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: John Kobrowski

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Mary Oswisky

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph F. Srnec

(Address) Route 1 Potlatch Ida

15. Filed Feb 21st 1920

J. M. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920, to Feb 16 1920, that I last saw her alive on Feb 16 1920, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) Chronic Nephritis

(Duration ..... yrs. — mos. 6 ds.

(Signed) E. K. Wolfe M. D.

Feb 1920 (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gth. Irwin (Potlatch) — DATE OF BURIAL: Feb 24 1920

20. UNDERTAKER — ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMB - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29175

Registered No. .....

1. PLACE OF DEATH.

County of Latah

City of Potlatch

(No. ....., ... St.)

Registration District No. 65

Primary Registration District No. 2145

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence May Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female.	white.	Married.

6. DATE OF BIRTH. Feb. (Month) 17 (Day) 1891 (Year)

7. AGE 29 Yrs. 6 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Washington.

10. NAME OF FATHER Willard Lattimer

11. BIRTHPLACE OF FATHER (State or Country) Not Known.

12. MAIDEN NAME OF MOTHER Adelia Richards.

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dave Johnson.

(Address) Potlatch

15. Filed March 3rd 1920 D. Jr. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28th 1920, to March 1st 1920, that I last saw her alive on March 1st 1920, and that death occured on the date stated above, at 9:50 A.M.

The CAUSE OF DEATH* was as follows: Influenza. Pneumonia

.....(Duration) ..... Yrs. ..... mos. 9. ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. Jr. Thompson. M. D.

3/3/1920 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bridgeport (Potlatch) Wash.	March 1920
20. UNDERTAKER	**ADDRESS**
E Irwin.	Palouse

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
File No. 29177
Registered No. ____

1. PLACE OF DEATH.
County of Latah
City of Onaway.
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Eldora Harris.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 5 (Day) 1869 (Year)

7. AGE: 57 Yrs. ____ Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: S. E. Shannon

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Her Hughart

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. E. Harris
(Address) Atlanta Iowa

15. Filed Feb. 20th 1920
D. J. Thompson
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14 1920, to Feb. 19 1920, that I last saw her alive on Feb. 19 1920, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Influenza with
Pneumonia following
(Duration) ____ Yrs. ____ mos. 5 ds.

Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. S. Dartt M. D.
2-20 1920 (Address) Palouse, Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Palouse
DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: ____
ADDRESS: Palouse

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 29178
Registered No.

1. PLACE OF DEATH
County of Latah
City of Troy
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Brannon
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Aug 22 (Month) (Day) 1 (Year)

7. AGE: Yrs. 69 Mos. 5 ds. 12
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: Harrison Brannon

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Ingersenbery
(Address) Troy Idaho

15. Filed Feb 4 1920 J E Pickerd Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to Feb 3 1920
that I last saw h~~im~~ alive on Feb 3 1920,
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 13 ds.
Contributory (Secondary): Hemiplegia
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) J M McCall M. D.
Feb 4 1920 (Address) Troy Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burnt Ridge — DATE OF BURIAL: 2-3-1920

20. UNDERTAKER: J E Pickerd — ADDRESS: Troy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi

City of Leadore

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 42

Primary Registration District No. 2153

(No. ....., ... St.)

File No. 25180

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella M McCormick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Mar (Month) 18 (Day) 1875 (Year)

7. AGE: 44 Yrs. 3 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bannock Mont

10. NAME OF FATHER: James M Colson

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Shaw

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lainy H McCormick
(Address) Hagerman Ida

15. Filed Mar 27 1920 Geo F Quarton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 16th 1920 to Mar. 20th 1920 that I last saw her alive on Mar. 20th 1920, and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Focal infection
(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) Dan B. Keller M. D.
3/22 1920 (Address) Leadore, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blue Bois Idaho — DATE OF BURIAL: 3-22 1920

20. UNDERTAKER: W.C. Woodell. — ADDRESS: Salmon

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi

City of Leadore

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 42

Primary Registration District No. 2152

(No. ....., ... St.)

File No. 29181

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Dugan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Not known ..... 1 .....
(Month) (Day) (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Quartz Miner

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not known Believed to be Minnesota.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J.W. McCourt

(Address) Leadore Idaho

15. Filed Mar. 17 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 16 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 5-40 P.M.
The CAUSE OF DEATH* was as follows: Natural Cause

Due to heart Trouble.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W.C. Doebler Coroner M.D.

3-17 1920 (Address) Salmon Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: W.C. Doebler

ADDRESS Salmon Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
(No. .... St.)

File No. 29183
Registered No. .....

1. PLACE OF DEATH.
County of Lemhi
City of Salmon.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Achsa Francis Benjamin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): School girl

6. DATE OF BIRTH. Jan 15 (Month) 4 (Day) 11 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Salmon City Lemhi Co.

10. NAME OF FATHER: John A Benjamin

11. BIRTHPLACE OF FATHER (State or Country): Dewitt Nebraska

12. MAIDEN NAME OF MOTHER: Martha Eckwald

13. BIRTHPLACE OF MOTHER (State or Country): Patterson N. Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) John A Benjamin

15. Filed 2/10 1920 M Deering Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. 19 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 18 1920, to Jany 19 1920, that I last saw her alive on Jany 19 1920, and that death occured on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Appendicitis

(Duration ..... yrs. ..... mos. 6 ds.

2/1 1920 (Signed) FJ Wright M. D.
(Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 1-20" 1920

20. UNDERTAKER: W. C. Hobbs
ADDRESS: Salmon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6VM8 - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 29184
Registered No. .....

1. PLACE OF DEATH
County of Lemhi
City of Gibbonsville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Elizabeth Bauer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. 3rd March 1 (Month) (Day) (Year)

7. AGE 36 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. ~~BIRTHPLACE~~ (State or Country): Mt Carmel Pa

10. NAME OF FATHER: Benj. [redacted] Evans

11. BIRTHPLACE OF FATHER (State or Country): Old mines Pennsylvania

12. MAIDEN NAME OF MOTHER: Elizabeth Philips

13. BIRTHPLACE OF MOTHER (State or Country): Cardy Co. Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Bauer
(Address) Gibbonsville Ida

15. Filed March 10 1920 M. Deming Greene Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January 27th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1919, to June 1th 1919, that I last saw her alive on June 1st 1919 and that death occured on the date stated above, at [redacted] M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. Don't know mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F B Wright M. D.
2/10 1920 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: W.C. Dahler — DATE OF BURIAL: 1-28 1920

20. UNDERTAKER: Gibbonsville — ADDRESS: Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47
Primary Registration District No.
File No. 29185
Registered No. 55

1. PLACE OF DEATH.
County of Lewis
City of Meyerce
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evert B. Benders

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 23 (Day) 1886 (Year)

7. AGE: 33 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Saline Co Neb.

10. NAME OF FATHER: W. K. Benders

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Theda Busboom

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Bessie Benders
(Address) Meyerce Ida.

15. Filed 3.24 1920 Albert Hunt Local Registrar

SYMS - YORK CO., PTRS. & BOBB. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1920 to March 21 1920, that I last saw h alive on March 20 1920, and that death occured on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Influenza
(Duration) 2 yrs. 7 mos. 11 ds.

(Signed) John F. Gust M. D.
19 (Address) Meyerce Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meyerce Cemetery
DATE OF BURIAL: 3-24 1920

20. UNDERTAKER: Albert Hunt
ADDRESS: Meyerce Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29186

Registered No. 7

1. PLACE OF DEATH.

County of Lemhi

City of Vollmer

Registration District No. 62

Primary Registration District No. 2129.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lydon.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. March 1 1920
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 14 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Vollmer Idaho

10. NAME OF FATHER None reported

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Bessie Adelia Lydon

13. BIRTHPLACE OF MOTHER (State or Country) Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) [illegible] McCoy
(Address) Vollmer Idaho

15. Filed 3/1 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 1 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1920 to March 1 1920, that I last saw h[illegible] alive on March 1 1920, and that death occured on the date stated above, at 2 [illegible] M.

The CAUSE OF DEATH* was as follows:
Pneumonia bilateral
(Secondary to Influenza)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

3/1 (Signed) [illegible] M. D.

3/1 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mc Coy Ranch — DATE OF BURIAL: 3/1 1920

20. UNDERTAKER: Fred Mc Coy — ADDRESS: Ko [illegible]

BYNS - YORK CO., PTRS. & BORS. 24858

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29188

Registered No. 5

1. PLACE OF DEATH.

County of Lewis

City of Ilo

(No. ....., ... St.)

Registration District No. 52

Primary Registration District No. 217

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Ringle, Ilo, Idaho

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Apr. (Month) 16, (Day) 1851. (Year)

7. AGE: 68 Yrs. 9 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Dan Peabody

11. BIRTHPLACE OF FATHER (State or Country): Ohio U.S.

12. MAIDEN NAME OF MOTHER: Esther Knickerbocker

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Luscombe

(Address) Kalmer Idaho

15. Filed 7/12 1920. C. C. Dunbar Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 11, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1920, to Feb. 11, 1920, that I last saw her alive on Feb. 11, 1920, and that death occured on the date stated above, at 5:45 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary) Carcinoma of Pancreas & Chronic Valvular Heart disease

(Duration 15 yrs. mos. ds.

(Signed) J. J. Darby M. D.

Feb 11, 1920 (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: North Star Nampa — DATE OF BURIAL: 2/15 1920

20. UNDERTAKER: W E Studland — ADDRESS: Caldwell

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 47
County of Lewis Primary Registration District No.
City of Nezperce (No. ....., ... St.)
File No. 29189
Registered No. 54

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mathias Kelly

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: April 1 1843
76 (Month) 11 (Day) 17 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Wm Kelly

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Donovan

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frances Kelly
(Address) Nezperce Idaho

15.
Filed 3-19 1920 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 17 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1920 to March 17 1920
that I last saw h.. alive on March 17 1920
and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Appendicitis

..... (Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Cirrhosis Kidneys
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nezperce Idaho
DATE OF BURIAL: 3-19 1920

20. UNDERTAKER: Albert Huff
ADDRESS: Nezperce Idaho

CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Mar 3 – 4 o'clock 1920

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29190

Registered No. 53

1. PLACE OF DEATH. Registration District No. 47

County of Lewis Primary Registration District No.

City of Nezperce (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Aubrey Orbison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
female	White	~~Widowed~~ Married

6. DATE OF BIRTH April 12 (Month) (Day) 1853 (Year)

7. AGE 66 yrs. 11 mos. ds. IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Lewisville Ky.

10. NAME OF FATHER VanDeventer

11. BIRTHPLACE OF FATHER (State or Country) Lewisville Ky.

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Ky —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Florence R. Johnson
(Address) Nezperce, Idaho.

15. Filed Mar 17 1920 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 28 | Mar 3 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~March~~ Mar 3 1920, to Mar 3 1920
that I last saw h alive on Mar 3 1920
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) yrs. mos. 2 ds.
Contributory (Secondary) Nephritis Arteriosclerosis
(Duration) yrs. mos. ds.

(Signed) John T. Grad M. D.
19 (Address) Nezperce Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Nezperce Idaho — DATE OF BURIAL Mar 4 1920

20. UNDERTAKER Albert Huff — ADDRESS Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 48 — 66
Primary Registration District No. 2137 2179
File No. 29191
Registered No. 4

1. PLACE OF DEATH
County of Lewis
City of Nuechete
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Hulda Lingren

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married
6. DATE OF BIRTH: Dec 15th 1881 (Month) (Day) 1 (Year)
7. AGE: 38 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....
9. BIRTHPLACE: Sweden (State or Country)
10. NAME OF FATHER: Andersonn
11. BIRTHPLACE OF FATHER: Sweden (State or Country)
12. MAIDEN NAME OF MOTHER: dont know
13. BIRTHPLACE OF MOTHER: Sweden (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. C. Downs
(Address) Nuechete Idaho
15. Filed 2/12 19 20 P. C. Donnelly Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 11th (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Had no Medical Attendant 19 ..... to 19 .....
that I last saw h..... alive on ..... 19 .....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Think it was Pneumonia
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Langley Ingraham M. D.
Feb 11 1920 (Address) Nuechete Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ilo Cem — DATE OF BURIAL: 2/12 19 20
20. UNDERTAKER: Ilo Furn Undr Co. ADDRESS: Ilo Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2066
File No. 25192
Registered No. 8

1. PLACE OF DEATH

County of Lincoln
City of Dietrich
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Buttrill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	single

6. DATE OF BIRTH: Dec (Month) 16 (Day) 1919 (Year)

7. AGE: Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: baby
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Robt. Buttrill

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Anna Whaley

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B P Jones
(Address) Shoshone

15. Filed Feb 24" 1920 J. Kinnan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920 to Feb 24 1920 that I last saw h.er alive on Feb 23 1920 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Probably Influenza
(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) B P Jones M. D.
2/24 1920 (Address) Shoshone

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone | DATE OF BURIAL: 2-25-1920

20. UNDERTAKER: O S Brennan | ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29193

Registered No. 7

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

Registration District No.

Primary Registration District No. 16

(No. , 1016 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Ann Morrow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Girl	White	

6. DATE OF BIRTH. July (Month) 22 (Day) 1919 (Year)

7. AGE ....Yrs. Mos. 7 ds. 12 | IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work....

(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER William James Morrow

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Mary Jo Martin

13. BIRTHPLACE OF MOTHER (State or Country) Indianna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) William James Morrow

(Address) Dietrich Idaho

15. Filed March 5th 1920 J. L. Stuen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Feb. 27 1920, ~~and~~ 191..., that I last saw her alive on Feb 27 1920, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary) Influenza

(Duration yrs. mos. 14 ds.

(Signed) W. H. Baugh M. D.

19.... (Address) per. B. Jones M.D. Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shoshone	3-6 1920
20. UNDERTAKER O. L. Brennan	ADDRESS Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 106
File No. 29194
Registered No. 6

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora May Pitts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) 15 (Day) 1872 (Year)

7. AGE: Yrs. 48 Mos. 5 ds. 18
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Stratchville Wis

10. NAME OF FATHER: Sam Dyer

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Caroline Higgins

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J W Pitts
(Address) Shoshone Idaho

15. Filed Mch 3rd 1920 J. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1920, to Mch 3 1920, that I last saw her alive on Mch 2 1920 and that death occured on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia
(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) Influenza ?
(Duration ..... yrs. ..... mos. 10 ds.
(Signed) C P Jones M. D.
19..... (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone
DATE OF BURIAL: 191

20. UNDERTAKER: D F Brannan
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVIMS - YORK CO., PTRS. & SDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2016
(No. ....., ... St.)

File No. 29195
Registered No. 5

1. PLACE OF DEATH.
County of Elmore
City of Mt. Home
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cecil W Munger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 3 1895
(Month) (Day) (Year)

7. AGE: 21 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R R Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: W Munger

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Ella Winn

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C C Munger
(Address) Shoshone Idaho

15. Filed February 14 1920 J L Fuller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191....
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Injury to lower right abdomen. R.R. wreck and near to Mountain Home Ida
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) T.B.
(Duration ..... Yrs. ..... mos. ..... ds.
(Signed) J L Fuller M. D.
2/14 1920 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plainview Texas
DATE OF BURIAL ..... 191...

20. UNDERTAKER: O L Brannan
ADDRESS: Shoshone

... - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5 29196
Registered No. 3

1. PLACE OF DEATH.
County of Lincoln
City of Richfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Bascom Montgomery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov. 29 1916 (Month) (Day) (Year)

7. AGE: 3 yrs. 2 mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Idaho

10. NAME OF FATHER: Henry Montgomery

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Julia Hilliard

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Harry Hilliard
(Address) Richfield Idaho

15.
Filed Jan. 27 1920 W. E. Bartlett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 28 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1920, to Feb 28 1920 that I last saw h[illegible] alive on Feb 28 1920 and that death occurred on the date stated above, at 7:50 M.

The CAUSE OF DEATH* was as follows:
Meningitis (Secondary)

(Duration) yrs. mos. 1 ds.
Contributory (Secondary) Influenza Pneumonia.
(Duration) yrs. mos. 15 ds.

(Signed) O. R. Bloom M. D.
2/29 1920 (Address) Richfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Richfield Cemetery — DATE OF BURIAL: Jan 27 1920

20. UNDERTAKER: Hugh Hendrix — ADDRESS: Richfield Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29197

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Lincoln
City of Richfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 1120
(No. ____, ____ St.)

2. FULL NAME James L Corley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 4 (Day) 1908 (Year)

7. AGE: 11 yrs. 7 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pendleton Ore

10. NAME OF FATHER: Emmet Corley

11. BIRTHPLACE OF FATHER (State or Country): Newton Co Mo

12. MAIDEN NAME OF MOTHER: Lucy Simonton

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emmet Corley
(Address) Richfield Idaho

15.
Filed March 10 1920 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20, 1920, to Feb 19 1920
that I last saw him alive on Feb 19 1920
and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ____ yrs. ____ mos. 7 ds.

Contributory (Secondary) Pulmonary Abscess following Pneumonia

(Duration) ____ yrs. ____ mos. 22 ds.

(Signed) O R Bloom M. D.

2/21 1920 (Address) Richfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] DATE OF BURIAL: Mar 10 1920

20. UNDERTAKER: [illegible] ADDRESS: Richfield Idaho

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 6 29198
Registered No. 4

1. PLACE OF DEATH.
County of Lincoln
City of Richfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 17
Primary Registration District No. 1150
(No. ....., ... St.)

2. FULL NAME Laura Winnifred Edwards

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1896 (Year)

7. AGE: 24 yrs. 1 mos. 17 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cheney Wash

10. NAME OF FATHER: F. O Rex

11. BIRTHPLACE OF FATHER (State or Country): Wash

12. MAIDEN NAME OF MOTHER: Laura A Andrews

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Edwards.
(Address) Richfield

15. Filed March 2 1920 R E Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: In Feb (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1920 to Feb 29 1920 that I last saw her alive on Feb. 29 1920 and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:
Mitral Insuffiency

(Duration) (2) yrs. mos. ds.
Contributory (Secondary) Influenza - child birth
(Duration) 2 yrs. mos. 6 ds.

(Signed) C E Bloom M. D.
3/1 1920 (Address) Richfield Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence. Kansas [illegible]

19. PLACE OF BURIAL OR REMOVAL: Richfield Cemetery
DATE OF BURIAL: .....191...

20. UNDERTAKER: [illegible]
ADDRESS: Richfield [illegible]

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 29199
Registered No. 4014

2. FULL NAME Christine G. Klingler
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: July (Month) 15 (Day) 1859 (Year)

7. AGE: 60 yrs. 6 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Konrad Waly

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna M. P. Datzner

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gattija Klingler
(Address) Rexburg

15. Filed 1/17 1920 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 1 (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/9 1919, to 1/17 1920, that I last saw her alive on 1/16 1920, and that death occurred on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows:
Perforating gastric ulcer
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Empyelas
(Duration) 6 yrs. ..... mos. ..... ds.

(Signed) G. L. Espe M. D.
1920 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg | DATE OF BURIAL: 1/20 1920

20. UNDERTAKER: John Phillips | ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. 29200

Registered No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Warren Sheldon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: March (Month) 3 (Day) 1874 (Year)

7. AGE: 45 Yrs. 11 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: William Sheldon

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Martha Cole

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Knickbergen

(Address) Carpenter, So. Dakota

15.

Filed ..... 19 .....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 28 1920 to February 22 1920 that I last saw h... alive on February 22 1920 and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Empyema

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) L. B. Evans M. D.

2/1 1920 (Address) Sugar City

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City, Idaho.

DATE OF BURIAL: Feb. 22 1920

20. UNDERTAKER: David Young

ADDRESS: REXBURG, IDA.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 [redacted]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 110
Primary Registration District No. 217
File No. 29201
Registered No. 39

1. PLACE OF DEATH.
County of Madison
City of Teton (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Barclay McKinlay
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 27 (Day) 1885 (Year)

7. AGE: 34 yrs. 1 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Geoge McKinlay

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margeret F. Barclay

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. McKinlay
(Address) Rexburg

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 28 1920, to January 29 1920, that I last saw h[illegible] alive on January 29 1920, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) D. B. Mann M. D.

January 29 1920 (Address) Driggs City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Teton
DATE OF BURIAL: 2/2 1920

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. — Registration District No. 180
County of Madison — Primary Registration District No. 2178 — File No. 29202
City of Independence (No. ....., ... St.) — Registered No. 25
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Hansen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Married

6. DATE OF BIRTH: April (Month) 4th (Day) 1849 (Year)

7. AGE: 70 yrs. 10 mos. 4 ds. — IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Holmes

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Hansen
(Address) Independence

15. Filed ..... 191... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. L. Espe M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Independence — DATE OF BURIAL: 2-11 1920

20. UNDERTAKER: J. R. Young — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29203
Registered No. 19

1. PLACE OF DEATH.
County of Rexburg
City of Madison
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178

2. FULL NAME Rachal Wood

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: May (Month) 17 (Day) 1919 (Year)

7. AGE: ..... yrs. 9 mos. 15 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rexburg

10. NAME OF FATHER Henry H. Wood

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Elizabeth Hendry

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry H. Wood
(Address) Rexburg

15.
Filed ..... 191....
..... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 2 (Day) 20 191.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 191.., to 3-2 191.., that I last saw h.. alive on 3-1 191.., and that death occurred on the date stated above, at 4 00 M.

The CAUSE OF DEATH* was as follows:
Pernicious Meningitis

(Duration) 2 yrs. 2 mos. ..... ds.
Contributory (Secondary) Lobar Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Walker M. D.
19.. (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: 3/4 191..

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. *See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19780

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 108
Primary Registration District No. 2178
File No. 29204
Registered No. 18

1. PLACE OF DEATH
County of Madison
City of Rigburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anthony Edward Metcalf
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: June (Month) 29 (Day) 1867 (Year)

7. AGE: 52 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gunnison, Sanpete Co

10. NAME OF FATHER: Anthony Metcalf

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sylvia Eliza Sanford

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. E. Metcalf
(Address) Rigburg, Idaho.

15. Filed 2/24 19 20 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1920 to Feb 24 1920, that I last saw him alive on Feb 24 1920, and that death occurred on the date stated above, at 2:30 M.
The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
2-25 1920 (Address) Rigburg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. 10 mos. 2 days. In the State 2 yrs. 10 mos. 2 days
Where was disease contracted if not at place of death?
Former or usual residence Rexburg, Idaho.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gunnison, Utah.	Feb. 28 1920
20. UNDERTAKER	ADDRESS
David Young	Rexburg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29206

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. **PLACE OF DEATH.**

Registration District No. 100

Primary Registration District No. 2178

County of Madison

City of Sunnydell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Delbert Baby Hemsaker

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** M

4. **COLOR OR RACE** W

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** (Write the word.) Baby

6. **DATE OF BIRTH.** Nov (Month) 26 (Day) 1919 (Year)

7. **AGE** Yrs. 1 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work... Babe

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. **BIRTHPLACE** (State or Country) Ida

10. **NAME OF FATHER** Adelbert Hemsaker

11. **BIRTHPLACE OF FATHER** (State or Country) Utah

12. **MAIDEN NAME OF MOTHER** Iswell Cowley

13. **BIRTHPLACE OF MOTHER** (State or Country) Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.**

(Informant) Mrs Hemsaker

(Address) Lyman

15.

Filed ..... 191.....

G. G. Clapp
Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**

2 (Month) 20 (Day) 1920 (Year)

17. **I HEREBY CERTIFY,** That I attended deceased from 2-8 1920, to 2-20 1920, that I last saw h... alive on 2-17 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. G. Clapp M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Lyman

DATE OF BURIAL 2/23 1920

20. **UNDERTAKER** Wyman

ADDRESS Rexburg

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 29207
Registered No. 16

1. PLACE OF DEATH
County of Fremont
City of Newdale
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Austin Ruddy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Unknown. (Month) (Day) 1848 (Year)

7. AGE: 72 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland.

10. NAME OF FATHER: Chas Ruddy.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Mary Kinnon

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Martha Jones.
(Address): 1737 E 8th Pueblo Colo.

15.
Filed ..... 19.....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920 to Feb 19 1920
that I last saw him alive on Feb 19 1920,
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Influenza
Broncho pneumonia
..... (Duration) — Yrs. — mos. 5 ds.
Contributory (Secondary)
..... (Duration) — yrs. — mos. — ds.
(Signed) J. Frank Watkins M. D.
Feb 20 1920 (Address) Drawhorn Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Wagonner — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1 x x
Primary Registration District No. 2 1 1 8
File No. 29208
Registered No. 28

1. PLACE OF DEATH.
County of Mad
City of Ref (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Aline Leatham

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Oct. (Month) 17 (Day) 1887 (Year)

7. AGE: 32 yrs. 3 mos. 29 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Arnold Dennis Quentrell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Alice Luthy

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Leatham
(Address) Rexburg

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 15 (Day) 20 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 191..., to 2-15 1920, that I last saw her alive on 2-15 1920, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Flu

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19.... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: 2/18 1920

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25209

Registered No. 27

1. PLACE OF DEATH.

Registration District No. 100

County of Madison

Primary Registration District No. 2102

City of Thornton (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Otto E. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Oct (Month) 3 (Day) 1859 (Year)

7. AGE: 60 yrs. 4 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Otto Anderson
(Address) Thornton

15. Filed 7/29 1920 G G Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3/1 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/20 1920, to 3/1 1920, that I last saw him alive on 2/28 1920, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Addisons Disease

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G G Espe M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 3/3 1920

20. UNDERTAKER: John R Phillips — ADDRESS: Replume

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 180
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 29210
Registered No. 26
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thelma Dorothy Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	

6. DATE OF BIRTH
June (Month) 28 (Day) 1919 (Year)

7. AGE
..... yrs. 7 mos. 23 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rexburg

10. NAME OF FATHER J. Eldorus Larsen

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Minnie D. Noller

13. BIRTHPLACE OF MOTHER (State or Country) New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Minnie Larsen
(Address) Rexburg

15.
Filed 2/21 1920 G G Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
2/20 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/8 1920, to 2/20 1920, that I last saw her alive on 2/19 1920, and that death occurred on the date stated above, at 5A M.

The CAUSE OF DEATH* was as follows:
~~Grippe~~
Lobar Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Gastroenteritis
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G G Espe M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	2/22 1920
20. UNDERTAKER	**ADDRESS**
John Phillips	Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 2921
Registered No. 23

1. PLACE OF DEATH.
County of Madison
City of Rexburg.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 9 (Day) 1899 (Year)

7. AGE: 20 Yrs. 3 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: W J Smith

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ema Smith

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W J Smith
(Address) Rexburg

15. Filed 2-3 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Feb. 2 1920, that I last saw h... alive on Feb. 2 1920, and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Flu
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Archer — DATE OF BURIAL 191...

20. UNDERTAKER: J Ryan — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PRS. & BKBS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 180
Primary Registration District No. 2175
File No. 29213
Registered No. 22

1. PLACE OF DEATH.
County of Madison
City of Moody Creek (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Thomas
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Aug. (Month) 29 (Day) 1863 (Year)

7. AGE
56 yrs. 5 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) America

10. NAME OF FATHER John Maughan

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER Mary Nibley

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) May Thomas
(Address) Moody Creek

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Flue
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Earl Teames M. D.
19.... (Address) Teton

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Teton	2/21 1920

20. UNDERTAKER	ADDRESS
John Phillips	Rexburg

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 108
Primary Registration District No. 2178
File No. 25214
Registered No. 21

1. PLACE OF DEATH.
County of Madison
City of Burton
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mamie Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: July (Month) 25 (Day) 1884 (Year)

7. AGE: 35 yrs. 6 mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: George McCullock

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Catherine Smith

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Catherine McCullock
(Address) Burton

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920, to Feb 23 1920, that I last saw her alive on Feb 20 1920, and that death occurred on the date stated above, at 4:20 M.

The CAUSE OF DEATH* was as follows:
Flu

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. / ..... ds.

(Signed) Parley Nelson M. D.
Feb 24 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton
DATE OF BURIAL ..... 191...

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 29215
Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Seymour Hinckley

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: April (Month) 30 (Day) 1874 (Year)

7. AGE: 45 yrs. 9 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Orza Erastus Hinckley

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Temperance Ricks

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clara Hinckley
(Address) Rexburg

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1920, to Feb 26 1920, that I last saw him alive on Feb 25 1920 and that death occurred on the date stated above, at 9:45 M.

The CAUSE OF DEATH* was as follows:
Organic Heart Disease

(Duration) 30 yrs. ..... mos. ..... ds.
Contributory (Secondary) Fever
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Farley Nelson M. D.
3-26 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: 2/30 1920

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Mad.

City of Archer

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ....., ... St.)

File No. 28216

Registered No. 37

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Kinnier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan. (Month) 21 (Day) 1920 (Year)

7. AGE: 65 yrs. ..... mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Stanbrook

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Leyington

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Kinnier
(Address) Archer

15.

Filed ..... 191...

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan. (Month) 19 (Day) 1935 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Slept Away
Body played out.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John B. Phillips M. D.

1/22 1935 (Address) Archer Rep.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: John Phillips | DATE OF BURIAL: 1/24 1935

20. UNDERTAKER: Archer | ADDRESS: Rep.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

File No. 29217

County of Madison

City of Rexburg (No. ....., ... St.)

Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lenard Walters Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Married

6. DATE OF BIRTH

May (Month) 31 (Day) 1854 (Year)

7. AGE

65 yrs. 8 mos. 22 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work Furnace Fireman

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE

(State or Country) Wales

10. NAME OF FATHER

Lenard Jones

11. BIRTHPLACE OF FATHER

(State or Country) England

12. MAIDEN NAME OF MOTHER

Sarah Walters

13. BIRTHPLACE OF MOTHER

(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Ricks

(Address) Rexburg, Idaho

15.

Filed ..... 191.... .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

1 (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 16 1920, to January 23 1920, that I last saw him alive on January 23 1920, and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Gastro intestinal Intoxication

..... (Duration) ..... yrs. ..... mos. 7 ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. T. Pasmore M. D.

..... 19.... (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg	Jan. 26 1920
20. UNDERTAKER	**ADDRESS**
David Young	Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 180
Primary Registration District No. 2178
File No. 29218
Registered No. 33

1. PLACE OF DEATH.
County of Madison
City of Lyman
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret A Atkinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 4th (Day) 1882 (Year)

7. AGE: 37 Yrs. 4 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: George E Pope

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Margaret Jones

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs A Atkinson
(Address) Lyman

15.
Filed ..... 191.....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1920, to Jan 30 1920, that I last saw her alive on Jan 29 1920 and that death occured on the date stated above, at 4:20 M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Farley Nelson M. D.
1-31 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Archer
DATE OF BURIAL: 2/1 1920

20. UNDERTAKER: Wilgoose
ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS, & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 108
Primary Registration District No. 2178
File No. 29219
Registered No. 34

1. PLACE OF DEATH.

County of .....
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Hunsaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 7 (Day) 1910 (Year)

7. AGE: 9 Yrs. 8 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ryley

10. NAME OF FATHER: Henry Hunsaker

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Sarah Simms

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Hunsaker
(Address) Ryley

15.
Filed ..... 191....
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1920, to Jan 31 1920, that I last saw her alive on Jan 31 1920, and that death occured on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:

Typhoid Fever

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. L. Estes M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: .....
DATE OF BURIAL: 2/2 1920

20. UNDERTAKER: J Rooney
ADDRESS: Ryley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

Parkinson

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Madison

City of Rexburg

Registration District No. 180

Primary Registration District No. 2176

(No. ....., ... St.)

File No. 29220

Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillis Irvin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 21 (Day) 1897 (Year)

7. AGE: 22 Yrs. 2 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William H Irvin

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Della Redd

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Della Redd

(Address) RF-D No 3 Ryley

15.

Filed ..... 191.....

..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. (Month) 3 (Day) 1920 (Year)

Jan 2

I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Feb 2 1920, that I last saw her alive on Feb 2 1920 and that death occured on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G W Parkinson M. D.

19..... (Address) Rexburg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ryley

DATE OF BURIAL: 2/3 1920

20. UNDERTAKER: Reynes

ADDRESS: Ryley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29221

Registered No. 32

1. PLACE OF DEATH
County of Madison
City of Plano (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 108
Primary Registration District No. 2178

2. FULL NAME Glenda Ellen Hunsley

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Babe

6. DATE OF BIRTH: June (Month) 31 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Plano

10. NAME OF FATHER: Clyde O Hunsley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Alice E Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. H. Peterson
(Address) Plano

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1920, to Feb 3 1920
that I last saw her alive on Feb 3 1920
and that death occurred on the date stated above, at 2 9. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Instrumental Delivery

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Bailey Nelson M. D.

2-3- 1920 (Address) Raybum Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plano
DATE OF BURIAL: 2/4 1920

20. UNDERTAKER: J Rymer
ADDRESS: Bailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

AYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29222

Registered No. 31

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Madison

City of Lyman

Registration District No. 100

Primary Registration District No. 2178

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delbert Kunsaker

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: June 27 (Month) 1891 (Day) (Year)

7. AGE: 28 yrs. 7 mos. 7 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Honeyville Utah

10. NAME OF FATHER: Lyman Kunsaker

11. BIRTHPLACE OF FATHER (State or Country): Brigham City Utah

12. MAIDEN NAME OF MOTHER: Mary Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Leslie D Kunsaker
(Address):

15.
Filed ..... 191...
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1920, to Feb 4 1920
that I last saw him alive on Feb 4 1920
and that death occurred on the date stated above, at 9P M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) 4 yrs. mos. ds.
Contributory Influenza
(Secondary)
(Duration) yrs. mos. ds.
(Signed) G L Espe M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Archie	2/7 1920

20. UNDERTAKER	ADDRESS
Wyoming	Rigby

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 217
(No. ..... St.)
File No. 29223
Registered No. 36

1. PLACE OF DEATH.
County of Madison
City of Lyman
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maud E. L. Sharp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Sept (Day) 2 (Year) 1884

7. AGE: 37 Yrs. 5 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Bryann. F Zimmerman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Pauline Swiger

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M Sharp
(Address) Lyman

15.
Filed ..... 191....
Local Registrar

EVANS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Feby (Day) 2 1912

17. I HEREBY CERTIFY, That I attended deceased from Feby Jan 2 1912, to Feby 2 1912, that I last saw her alive on Feby 2 1912 and that death occured on the date stated above, at 11 0m M.

The CAUSE OF DEATH* was as follows:
Influenza with
Pneumonia (Influenzal)
(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Wolfley M. D.
19..... (Address) Rexburg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Archer
DATE OF BURIAL: 2/5 1912

20. UNDERTAKER: J Bowers
ADDRESS: Ryley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Lyman
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2177
(No. ....., ... St.)

File No. 29224
Registered No. 29
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Blackburn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Married

6. DATE OF BIRTH: April (Month) 13 (Day) 1887 (Year)

7. AGE: 32 yrs. 9 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Chas Burns

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Susana Stacy

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lizzie Burns.
(Address) Lyman

15. Filed ..... 191.... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 2 1920 to Feb. 6 1920
that I last saw her alive on Feb 6 1920
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows: Influenza + Tobar Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary) Lobar - Pneumonia
(Duration) ..... yrs. ..... mos. 2 ds.
(Signed) O.O. Martin M. D.
2-6 1920 (Address) Replogle Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Archer	2/7 1920

20. UNDERTAKER	ADDRESS
Wyang	Replogle

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... , ... St.)

File No. 29225
Registered No. 38

1. PLACE OF DEATH.
County of Madison
City of Rigby

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Poole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 10 (Day) 1888 (Year)

7. AGE: 37 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. W. Lloyd

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah E. Jones

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Nelly Lloyd
(Address) Rigby

15. Filed 3/8 1920
G. G. Esplin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Acute Nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pregnancy
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) G. G. Esplin M. D.
19... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 3/4 1920

20. UNDERTAKER: Rigby — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 14

Primary Registration District No. 2013

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29226

Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Kidd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 5 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 12 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Rupert Idaho

10. NAME OF FATHER Carson Gilbert Kidd

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Nellie Florence

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carson Gilbert Kidd

(Address) Rupert Idaho

15.

Filed Mar 6 1920 E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1920, to Mar 5 1920, that I last saw her alive on Mar 5 1920, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Atelectasis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature Birth

.....(Duration ..... yrs. ..... mos. 1/2 ds.

(Signed) E. H. Elmore M. D.

3-6 1920 (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24858

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 19
County of ..... Primary Registration District No. 2015
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 29227
Registered No. 19
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Donna Marie Peck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: November (Month) 27th (Day) 1918 (Year)

7. AGE: 1 yrs. 2 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: (none)
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minidoka Co. Idaho

10. NAME OF FATHER: Thomas E. Peck

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Gina Hall

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed M Peck
(Address) Rupert Idaho.

15.
Filed 2-23 1920 E.T. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 4th 1920, to Feb 23" 1920 that I last saw her alive on Feb 22" 1920, and that death occurred on the date stated above, at 6:00 A. M.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) ..... yrs. ..... mos. 17 ds.

Contributory (Secondary): Broncho Pneumonia-Bilateral

..... (Duration) ..... yrs. ..... mos. 15 ds.

(Signed) Leland Fraser M. D.

..... 19..... (Address) Rupert, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was Disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29229
Registered No. 364

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Riley Dixon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 10 (Day) 1860 (Year)

7. AGE: 69 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: William Dixon

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Nancy Privitt

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs W.R.Dixon
(Address) Lewiston, Ida.

15. Filed Nov 10 1920 Roan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1920, to Feb 1 1920, that I last saw him alive on Feb 1 1920 and that death occured on the date stated above, at 10/30 P. M.

The CAUSE OF DEATH* was as follows:
Influenza
Pneumonia Hemorrhage

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Nephritis
(Duration 6 yrs. ..... mos. ..... ds.

(Signed) C. L. White M. D.
Feb 3 1920 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days
In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Ida.
DATE OF BURIAL: Feb. 4 1920

20. UNDERTAKER: H.R.Merchant
ADDRESS: Clarkston Wash.

BYRON - WEBER CO., PTRS. & BKBS. 24858

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2525

Registered No.

1. PLACE OF DEATH

County of Nez Perce

City of Southwick

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Della Mill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH May (Month) 15 (Day) 1842 (Year)

7. AGE 37 Yrs. 8 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Wis

10. NAME OF FATHER Osslock Olsen

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Mary Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Solomon Mill

(Address) Southwick Idaho

15. Filed 2 - 9 1920 E. E. Watts, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 4 1920, to Feb. 7 1920, that I last saw her alive on Feb. 7 1920, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Stonebarner M. D.

2/7 1920 (Address) Leland Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | **DATE OF BURIAL** Feb 8th 1920

20. UNDERTAKER W E Stallard | **ADDRESS** Gifford

W M Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 29232
Registered No. 42

1. PLACE OF DEATH
County of Nez Perce
City of Southwick (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Edwardine Neumann
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Female~~
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov. 24 (Month) (Day) 1918 (Year)

7. AGE: Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Southwick Ida

10. NAME OF FATHER Jake Neumann

11. BIRTHPLACE OF FATHER (State or Country) Mich.

12. MAIDEN NAME OF MOTHER Emma Frank

13. BIRTHPLACE OF MOTHER (State or Country) Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jake Neumann
(Address) Southwick

15. Filed 2-3 1920 E. E. Watts Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 2 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920 to Feb. 2 1920 that I last saw h[illegible] alive on Feb 2 1920 and that death occurred on the date stated above, at [illegible] M.
The CAUSE OF DEATH* was as follows: Influenza
(Duration) ..... Yrs. [illegible] mos. [illegible] ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
2/2 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cameron Cemetery — DATE OF BURIAL: Feb 3. 1920

20. UNDERTAKER: W Stoddard — ADDRESS: Gifford

Smith & Sons Gifford.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
(No. .... St.)

File No. 29234
Registered No. 48

1. PLACE OF DEATH.
County of Nez Perce
City of Southwick

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Alice Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. July (Month) 2nd (Day) 1859 (Year)

7. AGE 61 Yrs. 6 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Henry V. Jones

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Hulda Herrington

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Southwick Ida.

15. Filed 2 13 1920 E. E. Wacht Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan 26 Feb (Month) 26 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Feb 1st 1920, that I last saw h. alive on Feb 1st 1920, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Influenza with Complications
Has been in poor health for
Several years
(Duration) 0 Yrs. 0 mos. 6 ds.
Contributory (Secondary) Kidney & Liver diseases
(Duration Several years — yrs. — mos. — ds.
(Signed) Russell Truitt M. D.
1920 (Address) Southwick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Southwick Cemetery — DATE OF BURIAL Feb 3 1920

20. UNDERTAKER E. W. Jones ADDRESS Southwick Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 23235
Registered No. 49

1. PLACE OF DEATH

County of Jerome
City of Jerome
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Forbes Woody

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: [illegible] Mar. 27 1839 (Month) (Day) (Year)

7. AGE: 83 Yrs. 11 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: [illegible] Forbes

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: [illegible] Lydia Garland

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. John Glenn
(Address) Juliaetta Ida

15. Filed 2-13 1920
E E Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1920 to Feb [illegible] 1920 that I last saw her alive on Feb [illegible] 1920, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
General Decline
(Duration) [illegible] Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D W Stone M. D.
2/12 1920 (Address) Leland Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29236

Registered No. 44

1. PLACE OF DEATH.

County of Nez Perce

City of Gifford

(No. ....., ... St.)

Registration District No. 92

Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence June Overman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
F	white	single

6. DATE OF BIRTH.

Mar (Month) 24 (Day) 1919 (Year)

7. AGE

..... Yrs. 10 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER Nathan Overman

11. BIRTHPLACE OF FATHER

(State or Country) Kansas

12. MAIDEN NAME OF MOTHER Florence Coulter

13. BIRTHPLACE OF MOTHER

(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M Mortimore

(Address) Gifford Idaho

15.

Filed 2-12 1920

E. E. Watts
Local Registrar

SYMS - YORK CO., PTRS. & ASRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-5 1920, to 2-12 1920, that I last saw her alive on Feb 10 1920 and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) - Yrs. - mos. 12 ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Watts M. D.

2-14 1920 (Address) Gifford Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gifford Ida	2-13 1920
20. UNDERTAKER	**ADDRESS**
M. E. Stoddard	Gifford Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 6-35 M. 1-16-13

[redacted] CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29237

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont

City of Gifford

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 92

Primary Registration District No. 2170

(No. ..... St.)

2. FULL NAME John Thomas Webb

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 13 (Day) 1896 (Year)

7. AGE: 23 Yrs. 2 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Thomas Webb

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Amanda Mulkey

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas Webb
(Address) Gifford Idaho

15. Filed 2-29 1920 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191~ to ~ 191~, that I last saw him alive on Wednesday 10:30 Feb 27 1920 and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Fell over a ledge of rocks and fractured Skull

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Watts M. D.

2-29 1920 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Reubens, Lewis Co. | DATE OF BURIAL: Mar 1 1920

20. UNDERTAKER: A. E. Stoddard | ADDRESS: Gifford

DYER - YORK CO., PTRS. & BOOK. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
(No. ..... St.)

File No. 29238
Registered No. 46

1. PLACE OF DEATH
County of Nez Perce
City of Southwick
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Cornelius Wittman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov. (Month) 9 (Day) 1912 (Year)

7. AGE: about 7 yr. Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Latah Co Idaho

10. NAME OF FATHER: Frank Whitman

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Lydia Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Martin Thomas
(Address) Lenore Ida

15. Filed 2-9-1920 E E Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to Feb 8 1920, that I last saw h-m alive on Sunday Feb 8 1920 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia following Influenza
7 days (Duration) ..... Yrs. ..... mos. 7 ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James A Kelly M. D.
19 ..... (Address) Kendrick Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Teakean cemetery — DATE OF BURIAL: Feb. 9 1920

20. UNDERTAKER: W. E. Stoddard & Son Undertakers — ADDRESS: Gifford Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1909
(No. Ted Bird district St.)

File No. 29239
Registered No. 365

1. PLACE OF DEATH
County of Nez Perce
City of
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Eller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 16 (Day) 18 (Year)

7. AGE: Yrs. 4 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ——
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida,

10. NAME OF FATHER: Jas Eller

11. BIRTHPLACE OF FATHER (State or Country): Ire.

12. MAIDEN NAME OF MOTHER: Dolly Scott

13. BIRTHPLACE OF MOTHER (State or Country): Cal

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. A. Steward
(Address) Lewiston

15. Filed Mar 10 1920 Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —— 19..., to —— 19...
that I last saw h... alive on —— 19...,
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:
Influenza,
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary)
.....(Duration) .....yrs.....mos.....ds.
(Signed) P. A. Steward
19... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 2/3 1920

20. UNDERTAKER: J. Varsar — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
File No. 29240
Registered No. 366

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston Orchards (No. Lewiston Orchards St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie E. Bonney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Single

6. DATE OF BIRTH Aug. (Month) 3 (Day) 1843 (Year)

7. AGE 84 Yrs. 7 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Dress Maker former Occupation

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Charles Bonney

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Reynolds

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. M. McKissick

(Address) Lewiston Ida.

15.

Filed ..... 19.....

Rosa E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan'y 3rd 19 20, to Feb 2nd 19 20, that I last saw her alive on Feb 2nd 19 20 and that death occurred on the date stated above, at 10 20 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Bonner M. D.

Dec'd 19 20 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston — **DATE OF BURIAL** 2/4 1920

20. UNDERTAKER Lasson — **ADDRESS** Lewiston

Nurse

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. .... St.)

File No. 29241
Registered No. 367

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maud Edna Englis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. December (Month) 23 (Day) 1883 (Year)

7. AGE: 36 Yrs. 1 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: -----Norton

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Emmley Robair

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emma I. Farley
(Address) Lewiston, Ida.

15. Filed Mar 10 1920 — Wm. E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1920, to Feb 3 1920, that I last saw h..... alive on ..... 191.. and that death occured on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Primary)

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary): Influenza + Pneumonia

(Duration) ..... yrs. 1 mos. 15 ds.

(Signed) E. L. Wheeler M. D.

Feb 1920 (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Ida. — DATE OF BURIAL: Feb. 9 1920

20. UNDERTAKER: H.R.Merchant — ADDRESS: Clarkston Wash.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STUB - YORK CO., PTGS. & ENGR. 24655

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29242
Registered No. 368

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 421 7th Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John William Bollinger
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feby 1st (Month) 1910 (Year)

7. AGE: 10 Yrs. — Mos. 10 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston Ida

10. NAME OF FATHER: Wm Bollinger

11. BIRTHPLACE OF FATHER (State or Country): Brown Co Minn

12. MAIDEN NAME OF MOTHER: Ella Runge

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm Bollinger
(Address): Lewiston

15. Filed Mar 10 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1913 to Feb 11 1920
that I last saw h. alive on Feb 11 1920
and that death occurred on the date stated above, at 8 30 P.M.
The CAUSE OF DEATH* was as follows:
Heart Disease
& Chronic Convulsions.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Tuberculosis
(Duration) Yrs. mos. ds.
(Signed) E. L. White M. D.
Feb 2 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 2/12 1914

20. UNDERTAKER: Barson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29243
Registered No. 369

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 206, Lincoln St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm M Latimore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: January (Month) 29 (Day) 1856 (Year)

7. AGE: 63 Yrs. 5 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Watchman
(b) General nature of industry, business or establishment in which employed (or employer): Blackwell Lumber Co

9. BIRTHPLACE (State or Country): Walla, Co Ind

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. E. Stookey
(Address) Lewiston, Ida

15. Filed Mar 10 1920 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~~ 19~~ never to saw him alive. 19..... that I last saw h..... alive on ..... 19..... and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

Sudden
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) Edgar L Latuke M. D.

Feb 15 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cur. de Aline
DATE OF BURIAL: Feb 19 20

20. UNDERTAKER: C J Vassar
ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29244
Registered No. 370

1. PLACE OF DEATH
County of Nezperce
City of Lewiston Ida
(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Page

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	

6. DATE OF BIRTH: Aug (Month) 4 (Day) 1873 (Year)

7. AGE: 73 Yrs. 6 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: James Ingraham

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Nacy Brantley

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. H. Rees
(Address) Portland Ore.

15. Filed Mar 10 1920 Brown E Brue Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1920, to Feb 15 1920, that I last saw h alive on Feb 15 1920, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Flu - Pneumonia
Rotan.

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Edgar L. White M. D.
Feb 16 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Clarkston Washington

19. PLACE OF BURIAL OR REMOVAL: ~~Lewiston Idaho~~ | DATE OF BURIAL: 2/17 1920

20. UNDERTAKER: H. H. Merchant | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29245
Registered No. 29245

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. Joseph & Douglas St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victory V. Shove

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 21 (Day) 18 (Year)

7. AGE: 1 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lapwai I.

10. NAME OF FATHER: Victor Shove.

11. BIRTHPLACE OF FATHER (State or Country): Ore.

12. MAIDEN NAME OF MOTHER: Essie Goble.

13. BIRTHPLACE OF MOTHER (State or Country): Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Irvin H. Shove
(Address) Lapwai I.

15. Filed Mar 10 1920 Byron E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-17, 1920, to 2-18 1920, that I last saw h— alive on 2-18 1920, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Pneumonia, Bronchial

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) John N Alley M. D.

19 ..... (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston I. DATE OF BURIAL: 3/20 1920

20. UNDERTAKER: Hersa ADDRESS: Lewiston I.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 23246
Registered No. 372

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston
(No. St Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm S Adams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Widower

6. DATE OF BIRTH June (Month) 3 (Day) 1858 (Year)

7. AGE 61 Yrs. 8 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Matthew Adams

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Serrena Suthey

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J F Adams

(Address) 726-6 St

15. Filed Mar 10 1920 Lorn E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1920, to Feb 20 1920, that I last saw him alive on Feb 20 1920, and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobularis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W P Mercer M. D.

19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2½ days. In the State ..... yrs. ..... mos. 10 days

Where was disease contracted if not at place of death? Smyrna Wash

Former or usual residence Smyrna Wash

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Idaho	Feb 22 1920

20. UNDERTAKER	ADDRESS
C J Vasser	Lewiston Idaho

Dr Source

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29247
Registered No. 873

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nellie May Weatherman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Mar (Month) 13 (Day) 1873 (Year)

7. AGE: 46 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Noah Auspaugh

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Syrena Low

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Weatherman
(Address) Lewiston Idaho

15. Filed Mar 10 1920 — Emma E. Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Feb 23 1920, that I last saw her alive on Feb 23 1920, and that death occurred on the date stated above, at 2:45 P.M.

The CAUSE OF DEATH* was as follows:

Hysteric Epilepsy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Perkins. M. D.

2/23 1920 (Address) Lewiston Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston D. — DATE OF BURIAL: Mar 1st 1920

20. UNDERTAKER: J. Larsen — ADDRESS: Lewiston D.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29249
Registered No. 375

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Edwin Bradley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: July (Month) 21 (Day) 1845 (Year)

7. AGE: 76 Yrs. 7 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ct Connecticut

10. NAME OF FATHER: Jas. N. Bradley

11. BIRTHPLACE OF FATHER (State or Country): Connecticut

12. MAIDEN NAME OF MOTHER: Ellen Bradham

13. BIRTHPLACE OF MOTHER (State or Country): Connecticut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E. F. Coldren
(Address) Clarkston Wn.

15. Filed Mar 10 1920 Byron E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h.m alive on ..... 19.....
and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:
Was not seen until few minutes after death. Had valvular heart disease.
(Duration) years Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul W. Johnson M. D.
3/1 1920 (Address) Clarkston Wn.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Cem. DATE OF BURIAL: 3/2 1920

20. UNDERTAKER: H. P. Merchant ADDRESS: Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29250
Registered No. 876

1. PLACE OF DEATH
County of Lewis Pierce
City of Lewiston (No. 403 Adams St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Sarah J. Schantz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 13 (Day) 1859 (Year)

7. AGE: 30 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Luther Phillips

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary C Martin

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Everett A Schantz
(Address) Lewiston Ida

15. Filed Mar 10 1920 Swan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 26 1920, to February 29 1920, that I last saw h.r alive on February 29 1920, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Inflamatory Rheumatism after Influenza with other complications
(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) L F Inman M. D.
19..... (Address) 512 Main street

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 3/2 1920

20. UNDERTAKER: C J Voss — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Oneida — Registration District No. 3

City of Homedale — Primary Registration District No. 2005

(No. ....., ... St.)

File No. 29252

Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Atto Hoffman.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: ..... Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minnesota.

10. NAME OF FATHER: Atto Hoffman.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Vivian Reynolds

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Otto Hoffmann

(Address) Homedale. Idaho.

15. Filed 2-15- 1920 John L. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1920, to Feb 13 1920, that I last saw h[illegible] alive on Feb 13 1920, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Seaborn Hopper M D.

2/14 1920 (Address) Homedale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Feb 15 1920

20. UNDERTAKER: D. V. Peckham ADDRESS: Caldwell, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOXS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29253

Registered No. 32

1. PLACE OF DEATH

County of Owyhee

Registration District No. 3

Primary Registration District No. 2005

City of Homedale (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Wesley Shepperd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

6. DATE OF BIRTH: Sept (Month) 8 (Day) 1875 (Year)

7. AGE: 41 Yrs. 5 Mos. 4 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Civil Engineer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Geo. W. Shepperd

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Ruth J. Woods

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Caldwell Ida

15. Filed 2-14-1920 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1920, to Feb 12 1920, that I last saw h.sm alive on Feb 12 1920, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Acute Inflamatory Rheumatism
(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Simeon Hopper M. D.
2/14 1920 (Address) Homedale Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill, Caldwell | DATE OF BURIAL: FEB 15 1920

20. UNDERTAKER: Case Furniture Co. | ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 43

Primary Registration District No. 2120

File No. 29254

County of Owyhee

City of Murphy (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob H. Crawford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH: March 28, 1855 (Month) (Day) (Year)

7. AGE: 64 yrs. 9 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster & rancher
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bushes Store, Laurel Co, Kentucky

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Kentucky,

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Son of 14 yrs. - J. L. Crawford
(Address) Joseph Oregon

15. Filed Jany. 21, 1920 W. H. Schuyler M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 10, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ Coroner's Inquest ~~1/01~~, to Jany. 10 1920, at 11 o'clock P.M. that I last saw h— alive on ——— 191—, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows: Crushed by tipping over on him of "Tank" (waggon) of water (5,000 to 6,000 lbs) about 7 miles from Murphy, Ida. - Death instantaneous.

——— (Duration) ——— yrs. ——— mos. ——— ds.

Contributory (Secondary) .....

——— (Duration) ——— yrs. ——— mos. ——— ds.

(Signed) W. H. Schuyler M. D.

Jan 11, 1920 (Address) Co. Coroner, Owyhee Co. - Murphy Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa, Idaho	Jany. 17, 1920
20. UNDERTAKER	**ADDRESS**
J. K. Robinson	Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29255

Registered No.

1. PLACE OF DEATH.

County of Owyhee

City of Rockville, (No. 2120 St.)

Registration District No.

Primary Registration District No. 43

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fanbiago Billboa,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White. Caucasian (Basque)

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH – (age given as 52, but looks much older. – though she specifies year of birth as 1866 or 7)

(Month) (Day) (Year) 1866 or 7

7. AGE – given as 52 and as 55 years, (looks 10 years older)

55 yrs. — mos. — ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ... Sheepherder & Camp tender

(b) General nature of industry business, or establishment in which employed (or employer) (Foreman for Simon Acordagoidia Sheepmen)

9. BIRTHPLACE (State or Country) Spain. Viscaya.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Spain, Viscaya.

12. MAIDEN NAME OF MOTHER Marie — (?)

13. BIRTHPLACE OF MOTHER (State or Country) Spain. Vizcaya.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Simon Acordagoidia

(Address) Jordan Valley, Or. & Caldwell, Ida.

15.

Filed Jany. 26. 1920 W. H. Schuyler. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January, (Month) 24, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191..., to 191..., (about)

~~that I~~ last ~~saw him~~ he was seen alive on January 14, 70. 1920 (about)

and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows: Dropped dead, apparently from natural causes on stage-road from Homedale to Jordan Valley, – Said to have suffered from "heart-spells" – no signs of violence or a struggle this horse + dog were with the body, when picked up, 2 miles from State line. (Duration) ... yrs. ... mos. ... ds.

~~Contributory~~ Probably heart disease of ~~(Secondary)~~ some duration as friends testified to "heart-spells"? (Duration) ... yrs. ... mos. ... ds.

(Signed) W. H. Schuyler, Coroner, M. D.

Jan. 15, 1920 (Address) Murphy, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

Body picked up & brought to Rockville by stage driver J. H. Knapp.

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

~~Not long dead when found.~~ ~~Where was disease contracted if not at place of death?~~ & death undoubtedly due to natural causes.

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Unknown

DATE OF BURIAL ... 191...

20. UNDERTAKER: Unknown

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 23556
Registered No. 14

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Washington Butt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 17 (Day) 1864 (Year)

7. AGE: 56 Yrs. — Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Parker Butt

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Martha Esley

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) [illegible] Payette

15. Filed Feb 19 1920 J. O. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1920 to Feb 19 1920 that I last saw him alive on Feb 18 1920 and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:

Influenza —
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Lobar Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Woodward M. D.
2/19 1920 (Address) Payette, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	Feb 19 1920
20. UNDERTAKER: Glenn C Landon	ADDRESS: Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
(No. ..... St.)

File No. 2925
Registered No. 15

1. PLACE OF DEATH
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Noot
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Aug (Month) 6 (Day) 1838 (Year)

7. AGE
81 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Surveyer & Civil Eng
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) S. Wales

10. NAME OF FATHER Wm Noot

11. BIRTHPLACE OF FATHER (State or Country) S. Wales

12. MAIDEN NAME OF MOTHER Sarah Upton

13. BIRTHPLACE OF MOTHER (State or Country) S. Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs William Noot
(Address) Payette

15. Filed March 7 1920 J. C. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1, 1920, to Feb 16 1920, that I last saw h[illegible] alive on Feb 16 1926, and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:

Dementia Praecox
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) 5 yrs. ..... mos. ..... ds.
(Signed) J. E. Howard M. D.
2/18 1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Payette Ida DATE OF BURIAL Feb 18 1920

20. UNDERTAKER D. A. Nidan ADDRESS Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 29258
Registered No. 1

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nephi Purcell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: August (Month) 9 (Day) 1846 (Year)

7. AGE: 73 Yrs. 4 Mos. 22 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer and Trapper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): La Port Ind.

10. NAME OF FATHER: Ben. Purcell

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Nancy Tyler

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. M. Stone
(Address) Payette, Ida.

15. Filed Jan 3 1920 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h.. alive on ..... 19.....
and that death occurred on the date stated above, at 2:00 P. M.
The CAUSE OF DEATH* was as follows:
Not known. Found dead on Payette Heights about four miles from Payette
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J C Woodward M. D.
1/3 1920 (Address) Payette Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Jan 4 1920
20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 29259
Registered No. 3

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel McNeal
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 25 (Day) 1902 (Year)

7. AGE: 17 Yrs. 11 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ore

10. NAME OF FATHER: Geo Pickelsimer

11. BIRTHPLACE OF FATHER (State or Country): Tex

12. MAIDEN NAME OF MOTHER: Dora McEntire

13. BIRTHPLACE OF MOTHER (State or Country): Tex

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry McNeal
(Address) Payette Idaho

15. Filed Jan 26 1920 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1920, to Jan 25 1920
that I last saw h.. alive on Jan 25 1920
and that death occurred on the date stated above, at 4 A. M.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Paralysis of lower and upper Ext.
(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) J. L. McDonald M. D.
1-26 1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Jan 26 1920
20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 25200
Registered No. 4

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katy Koscisan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 3 (Day) 1897 (Year)

7. AGE: 23 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Joe Dornbach

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Specht
(Address) Payette Ida.

15. Filed Jan 27 1920 J. C. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 22 1920 to Jan 26 1920
that I last saw h[illegible] alive on Jan. 26 1920,
and that death occurred on the date stated above, at 7[illegible] A.M.
The CAUSE OF DEATH* was as follows:
Gall stones with probable
rupture of gall bladder

(Duration) ..... Yrs. 7 mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. A. Avery M. D.
1/26/ 1920. (Address) Payette Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Jan 27 1920
20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 29261
Registered No. 7

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elma Lorane Hoyt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 19 (Day) 1919 (Year)

7. AGE: 0 Yrs. 5 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ~
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Payette Ida

10. NAME OF FATHER: Anson E Hoyt

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Ada G. Farlow

13. BIRTHPLACE OF MOTHER (State or Country): Moncato Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dora A Adams
(Address) Caldwell, Idaho

15. Filed Feb 1 1920 19 ..... J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920, to Jan 31 1920, that I last saw h[illegible] alive on Jan 31 1920 and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:
Influenza

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Bronchial Pneumonia
(Duration) ..... yrs. ..... mos. 4 ds.
(Signed) J C Woodward M. D.
2/3 1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Feb 1 1920

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29262.
Registered No. 8

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Florence Wallace Farlow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	single

6. DATE OF BIRTH: Aug (Month) 12 (Day) 1899 (Year)

7. AGE: 20 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: J. W. Farlow

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Eva Wharhmay

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. W. Farlow
(Address) Lenox. Idaho

15. Filed Feb 4 1920 J. C. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920 to Feb 3 1920
that I last saw him alive on Feb 3 1920
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Flu –

(Duration) Yrs. ..... mos. 8 ds.
Contributory (Secondary) Labor Pneumonia
(Duration) ..... yrs. ..... mos. 8 ds.

(Signed) J. R. Woodward M. D.
2/4 1920 (Address) Payette Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Norcatur Kansas	19

20. UNDERTAKER	ADDRESS
Glenn Landon	Payette Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 29263
Registered No. 11

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Hayes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: March (Month) 2 (Day) 1840 (Year)

7. AGE: 80 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Aden
(Address) Payette Idaho

15. Filed Feb. 10 1920 J. C. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1918, to Feb. 7 1920, that I last saw her alive on Feb. 7 1920, and that death occurred on the date stated above, at 7:00 P. M.
The CAUSE OF DEATH* was as follows:
Senility
(Duration) Indefinite yrs. ..... mos. ..... ds.
Contributory (Secondary) Cardiac failure
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. H. Avery M. D.
2/10/1920 (Address) Payette, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: Feb 11 1920

20. UNDERTAKER: Glenn C Landon
ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
(No. ..... St.)

File No. 29204
Registered No. 12

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henrietta Bosley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: January (Month) 25 (Day) 1835 (Year)

7. AGE: 85 Yrs. — Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Household
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Joshua Maisa

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Sarepta Haines

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): L. E. Keeler
(Address): Payette Idaho

15. Filed Feb 10 1920. J. C. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1918, to Feb 7, 1920, that I last saw her alive on Feb 7, 1920, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Indefinite yrs. ..... mos. ..... ds.

Contributory (Secondary) Cardiac failure

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.

2/10/1920 (Address) Payette, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ottawa Kansas — DATE OF BURIAL 19

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29205
Registered No. 13

Registration District No. 4
Primary Registration District No. 1008
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Fayette
City of Payette

2. FULL NAME Nancy Ann Bowman.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed.

6. DATE OF BIRTH: March (Month) 3rd (Day) 1846 (Year)

7. AGE: 73 Yrs. 11 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeping
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana Hendricks Co

10. NAME OF FATHER: Taylor

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Rachellum Taylor

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. M. Bumasters
(Address) [illegible]

15. Filed Feb 15 1920 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 13 1920 to Feb. 14 1920 that I last saw h[illegible] alive on Feb 14 1920 and that death occurred on the date stated above, at 2.30 P.M.
The CAUSE OF DEATH* was as follows:
Intestinal Obstruction
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J.C. Woodward M. D.
2/15/1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ola Idaho — DATE OF BURIAL: Feb 17 1920

20. UNDERTAKER: Glenn Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 5-1

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29266
Registered No.

1. PLACE OF DEATH
County of Payette
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Edward Allison Linck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June 24th 1860 (Month) (Day) (Year)

7. AGE: 59 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Litchfield, Illinois

10. NAME OF FATHER: Phillip C Linck

11. BIRTHPLACE OF FATHER (State or Country): Baden Germany

12. MAIDEN NAME OF MOTHER: Francis Curlew

13. BIRTHPLACE OF MOTHER (State or Country): Litchfield Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred L Linck
(Address): Payette Idaho

15. Filed: Jan 5, 1920 — C. C. Payton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 13, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1919, to Jan 13 1920
that I last saw h~~im~~. alive on Jan 13 1920
and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:

Myocarditis & Chronic Passive Congestion
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) William J Weese M. D.
1/14 1920 (Address) Ontario, Ore

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL 19

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29267
Registered No.

Registration District No.
Primary Registration District No.

1. PLACE OF DEATH

County of Payette
City of Fruitland
If death occurs away from usual residence, give facts called for under special information.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME ~~Mrs C B Griner~~ Juanita Griner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH Feb (Month) 18 (Day) 1920 (Year)

7. AGE 10 Yrs. — Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Clarence B Griner

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Zora Mae Jones

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O W Jones
(Address) Fruitland Ida.

15. Filed Feb 23 1920 L. L. Caxton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 22. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920 to Feby 22, 1920
that I last saw h[illegible] alive on Feby 22 1920
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Influenza — Influenza
Pneumonia
Empyema
(Duration) Yrs. mos. 24 ds.
Contributory (Secondary) Intestinal Hemorrhage
(Duration) yrs. mos. 03 ds.

(Signed) L. L. Caxton M. D.
2/23 1920 (Address) Fruitland

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Payette Idaho — **DATE OF BURIAL** Feb 23 1920

20. UNDERTAKER Glenn C Landon — **ADDRESS** Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29268
Registered No.

1. PLACE OF DEATH
County of Payette
City of Fruitland
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Clarence B. ~~Duncan Wilson~~ Grimmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 25 (Day) 1888 (Year)

7. AGE: 32 Yrs. 11 Mos. 34 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: D.W. Grimmer

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: — Burnell

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O.D. Jones
(Address) Payette Ida

15. Filed Feb 10, 1920 E. C. Payton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 1 1920 to Feb 9, 1920 that I last saw h-im alive on Feb 9, 1920 and that death occurred on the date stated above, at 5-15 A M.
The CAUSE OF DEATH* was as follows:

Influenza
(Duration) Yrs. mos. 9 ds.
Contributory (Secondary) Pneumonia
(Duration) yrs. mos. 4 ds.
(Signed) E. C. Payton M. D.
2-9 1920 (Address) E. C. Payton

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida
DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER: Glenn & Landon
ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

51

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

29269

File No.

Registered No.

1. PLACE OF DEATH

County of Payette

City of Fruitland (No. St.)

Registration District No. 4

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank D Rands

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH Sept Feb 2 1888
(Month) (Day) (Year)

7. AGE 31 Yrs. 4 Mos. 27 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) South Dakota

10. NAME OF FATHER John Rands

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Elvira E. Brown

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edna Rands
(Address) Fruitland Ida

15. Filed Feb 6 1920 C. C. Payton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan. 29 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920, to Jan 28 1920, that I last saw him alive on Jan 28 1920, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Double Lobar Pneumonia

(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Spanish influenza
(Duration) yrs. mos. ds.

(Signed) C. N. Avery M. D.
2/5/1920 (Address) Payette, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Payette Ida | DATE OF BURIAL Feb 19

20. UNDERTAKER D N Adair | ADDRESS Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29270

Registered No.

1. PLACE OF DEATH

County of

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arien C Rands

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Jan (Month) 22 (Day) 1885 (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): S. Dakota

10. NAME OF FATHER: John Rands

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Elvira E Brown

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Rands
(Address)

15. Filed Feb 6, 1920 C. C. Payton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 29 1920, to February 3 1920, that I last saw him alive on February 3 1920, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ....Yrs. mos. 6 ds.

Contributory (Secondary) Spanish Influenza

(Duration) ....yrs. ....mos. ....ds.

(Signed) O. H. Avery M. D.

2/4 1920 (Address) Payette Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Payette Ida DATE OF BURIAL Feb 4 1920

20. UNDERTAKER J. H. Adair ADDRESS Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2971

Registered No.

1. PLACE OF DEATH
County of Payette
City of Fruitland
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura A Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 6 (Day) 1875 (Year)

7. AGE: 44 Yrs. ..... Mos. 7 ds. 8
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Peter Linker

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.K. Baker
(Address) Fruitland

15. Filed Jan 15 1920 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920 to Jan 14 1920
that I last saw her alive on Jan 13 1920,
and that death occurred on the date stated above, at 12 10 M.
The CAUSE OF DEATH* was as follows:
Influenza Pneumona

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 10 ds.
(Signed) C. C. Paxton M. D.
1/14 1920 (Address) Fruitland

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida
DATE OF BURIAL: Jan 1920

20. UNDERTAKER: J.H. Adair
ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 2009
(No. ....., ... St.)

File No. 29272
Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Payette
City of Falk

2. FULL NAME Wm A. Neal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH: April (Month) 12 (Day) 1849 (Year)

7. AGE: 71 yrs. 9 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Jesse Neal

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Adkerson

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. La Crone
(Address): New Plymouth Ida.

15.
Filed Jan 12 1920 Wm J Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920, to Jan 11 1920, that I last saw h[illegible] alive on Jan 11 1920 and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J. Drysdale M. D.
1-12 1920 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: H. F. Knight — DATE OF BURIAL: Jan 13 1920

20. UNDERTAKER: New Plymouth Ida — ADDRESS: Kennedy Cemetery New Plymouth

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 1009
File No. 23273
Registered No. 2

1. PLACE OF DEATH.
County of Payette
City of New Plymouth (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie E. Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: March (Month) 5 (Day) 1856 (Year)

7. AGE: 63 yrs. 10 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Robert Waugh

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. W. Anderson
(Address) New Plymouth, Ida

15.
Filed Jan. 24 1920 Wm J. Dryedale Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan Jan 16 1920, to Jan 20 1920, that I last saw her alive on Jan 20 1920, and that death occurred on the date stated above, at 10 [redacted] P.M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) General debility

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm J. Dryedale M. D.
1-27-1920 (Address) New Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: H. F. Knight — DATE OF BURIAL: Jan 22 1920

20. UNDERTAKER: New Plymouth — ADDRESS: New Plymouth

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 6-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5

Primary Registration District No. 1009

File No. 29274

Registered No. 3

1. PLACE OF DEATH.

County of Payette

City of New Plymouth

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin F. Swatman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb. (Month) 13 (Day) 1841 (Year)

7. AGE: 59 Yrs. ..... Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Druggist
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Benjamin F. Swatman

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Lydia Gibbs

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Josie E. Swatman
(Address) New Plymouth

15. Filed 3-4 1920 — Wm J. Drysdale, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 27 (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from several years - 191 ..... to 191 .....,
that I last saw him alive on Feb 27 1920,
and that death occured on the date stated above, at 11:50 P.M.
The CAUSE OF DEATH* was as follows:
Mucous - colitis

(Duration) several - Yrs. ..... mos. ..... ds.
Contributory (Secondary) Hypostatic pneumonia
(Duration ..... yrs. ..... mos. 4 wks ds.

(Signed) Wm J. Drysdale M. D.
3-4 1920 (Address) New Plymouth Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Ida — DATE OF BURIAL: March 1920

20. UNDERTAKER: A. Meyer — ADDRESS: New Ply-

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

29275 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2
Registered No. 86
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of Am Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 2072
(No. Baltrams Hospital St.)

2. FULL NAME John J. Mehlhaff

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. April (Month) 25 (Day) 1874 (Year)

7. AGE: 45 Yrs. 9 Mos. 7 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Jacob Mehlhaff

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Christine Leitchke

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Christine Mehlhaff
(Address) Am Falls

15. Filed 2/3 1920 Richard T. Nott Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28th 20 to Feb 2nd 1920
that I last saw h[illegible] alive on Feb 2nd 1920
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of stomach and liver
about
(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) Richard T. Nott M. D.
2/3 1920 (Address) American Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: American Falls — DATE OF BURIAL: 2/3 1920

20. UNDERTAKER: A. T. Hagen — ADDRESS: Am Falls Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

25 29216

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
(No. ....., ... St.)

File No. 2
Registered No. 87
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of Ann Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bettsden Christa Davis

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Unmarried

6. DATE OF BIRTH. Nov. (Month) 16 (Day) 1918 (Year)

7. AGE 1 Yrs. 2 Mos. 28 (28) ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Walter A. Davis

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Alice Billingsley

13. BIRTHPLACE OF MOTHER (State or Country) Washington ~~Tennessee~~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter A. Davis
(Address) Ann Falls

15. Filed 2/4 1920 Richard F. North Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30th 1920 to Feb 4th 1920 that I last saw her alive on Feb 4th 1920 and that death occurred on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) ... Yrs. ... mos. 14 ds.

Contributory (Secondary) Lobular Pneumonia

(Duration) ... Yrs. ... mos. 6 ds.

(Signed) Richard F. North M. D.

2/4 1920 (Address) American Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Falls View Cem. DATE OF BURIAL 2/5 1920

20. UNDERTAKER H. P. Hager ADDRESS Am. Falls

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

29277

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 2
Registered No. 88

1. PLACE OF DEATH.
County of Power
City of .....
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Reuben Henry Nen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 27 (Day) 1919 (Year)

7. AGE: Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Christian Nen

11. BIRTHPLACE OF FATHER (State or Country) Russia

12. MAIDEN NAME OF MOTHER Annetmia Dasse

13. BIRTHPLACE OF MOTHER (State or Country) N. Dak

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed 9/1 1920 R. T. North Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1919, to July 5 1920, that I last saw h[illegible] alive on July 3 1919, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebritis.

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Schulz M. D.
2/6 1920 (Address) Lincoln Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: German Evangelical Cemetery | DATE OF BURIAL: July 6 1920

20. UNDERTAKER: Family | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - VOSK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

29278 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2
Registered No. 79
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 25
Primary Registration District No. W 7 2

1. PLACE OF DEATH
County of Ponna
City of Ann Falls
If death occurs away from usual residence, give facts called for under special information.
(No. St. Bethany Hospital St.)

2. FULL NAME Martha Pass

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married
6. DATE OF BIRTH: June 6 1896 (Month) (Day) (Year)
7. AGE: 23 Yrs. 8 Mos. ——— ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Oregon
10. NAME OF FATHER: Julius Villwock
11. BIRTHPLACE OF FATHER (State or Country): Russia
12. MAIDEN NAME OF MOTHER: ———
13. BIRTHPLACE OF MOTHER (State or Country): Poland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adam Pass
(Address) Ann Falls
15. Filed 3/1 1920 R. J. Nott Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby 6 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1920 to Feb 6 1920
that I last saw her alive on Feby 6 1920
and that death occurred on the date stated above, at 11.40 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia-Bronchial
(Duration) Yrs. mos. 9 ds.
Contributory (Secondary): Influenza & Pregnancy
(Duration) Yrs. mos. ds.
(Signed) C. F. Schleck M. D.
2/7 1920 (Address) Ann Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Restlawn Cem Ann Falls — DATE OF BURIAL: 2/7 1920
20. UNDERTAKER: H P Hager — ADDRESS: Ann Falls

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

29279

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2
Registered No. 10
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 25
Primary Registration District No. W72
(No. ....., ... St.)

1. PLACE OF DEATH
County of Power
City of Am. Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Baugh

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Mar (Month) 2 (Day) 1885 (Year)

7. AGE: 34 Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Samuel Baugh

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Matilda Humphreys

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. Baugh
(Address) Am. Falls

15. Filed 3/1 1920 R. J. Noth Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1920 to Feb 11 1920
that I last saw him alive on Feb 10th 1920
and that death occurred on the date stated above, at 1 a. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
following Influenza
about 6
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Richard F. Mott M. D.
2/11 1920 (Address) Am. Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fallsview Cem — DATE OF BURIAL: 2/12 1920

20. UNDERTAKER: H. P. Hyer — ADDRESS: Am. Falls, Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29280

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2070
File No. 2
Registered No. 91

1. PLACE OF DEATH.
County of Power
City of American Falls (No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Emily Ross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. 13 1920 (Month) (Day) (Year)

7. AGE: 9 Yrs. 0 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Fremont Co, Idaho

10. NAME OF FATHER: John Martin Ross

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Esther Heckman

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Martin Ross
(Address) American Falls, Ida.

15. Filed 3/1 1920 R B Mott Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 11 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1920 to Feb 11 1920 that I last saw her alive on Feb 10th 1920 and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Epilepsy (Severe type)
about.
(Duration) 7 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Richard B Mott M. D.
2/11 1920 (Address) American Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Amer. Falls. DATE OF BURIAL: 2/12 1920

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 25 — 29281

Primary Registration District No. 2072

State of Idaho BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2
Registered No. 92
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Power

City of Am Falls
If death occurs away from usual residence, give facts called for under special information.

(No.) 13 Ottaway Hospital (St.)

2. FULL NAME Letha V. Parson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH. Sept (Month) 7 (Day) 1903 (Year)

7. AGE 16 Yrs. 5 Mos. 7 ds. IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER James W. Parsons

11. BIRTHPLACE OF FATHER (State or Country) Missouria

12. MAIDEN NAME OF MOTHER Oline Blaylock

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Duncan
(Address) Aberdeen

15. Filed 3/1 1920 R. J. Notts Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2nd 1920 to Feb 13 1920
that I last saw her alive on Feb 12 1920
and that death occurred on the date stated above, at 12.10 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia followed by Pleurisy with Effusion of Left Side (Empyema)
(No medical attention during this illness)
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) General Septicaemia following Pneumonia abscess
(Duration) ... Yrs. ... mos. ... ds.

(Signed) Richard R Notts M. D.
2/13 1920 (Address) American Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence Aberdeen Ida

19. PLACE OF BURIAL OR REMOVAL Fallview Cem — DATE OF BURIAL 2/15 1920

20. UNDERTAKER Hager — ADDRESS Am Falls

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

29282 State of Idaho BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 93
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of Am Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 25
Primary Registration District No. 2072
(No. ....., ... St.)

2. FULL NAME John J. Schafer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Aug. (Month) 5 (Day) 1892 (Year)

7. AGE: 27 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): Public Garage

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Jacob Schafer

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Ziler

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Ford
(Address) Am. Falls Idaho

15. Filed 3/1/..... 1921. R. J. Notts Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11th 1920 to Feb 14 1920
that I last saw h[illegible] alive on Feb 14th 1920
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) .... Yrs. .... mos. 3 ds.

Contributory (Secondary) Acute Bronchitis

(Duration) .... Yrs. .... mos. 2 ds.

(Signed) Richard R. Notts M. D.
Feb 16 1920 (Address) Am Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Odessa Wash — DATE OF BURIAL: Feb 19th 1920

20. UNDERTAKER: A R Hage — ADDRESS: Am Falls

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH 29283

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2
Registered No. 94
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of American Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 25
Primary Registration District No. 2072
(No. ....., ... St.)

2. FULL NAME Eleanor Anna M. White

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 8 (Month) (Day) 1848 (Year)

7. AGE: 71 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Penn.

10. NAME OF FATHER: Jacob Mastellar

11. BIRTHPLACE OF FATHER
(State or Country) Penn.

12. MAIDEN NAME OF MOTHER: Eleanor Blaine

13. BIRTHPLACE OF MOTHER
(State or Country) New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eleanor Mary Sullivan
(Address) American Falls Ida

15. Filed Feb 21 1920 Richard F. Noth
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920 to Feb 19 1920
that I last saw her alive on Feb 19 1920
and that death occurred on the date stated above, at 6.45 P. M.

The CAUSE OF DEATH* was as follows:
Left Hemiplegia as a sequelae of Apoplexy
(Duration) 5 Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) .... Yrs. .... mos. .... ds.

(Signed) Richard F. Noth M. D.
2/21 1920 (Address) American Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 14 yrs. .... mos. .... days. In the State 14 yrs. .... mos. .... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Kansas

19. PLACE OF BURIAL OR REMOVAL: Walls View Cem, Am Falls — DATE OF BURIAL: Feb 21. 1920

20. UNDERTAKER: H. L. McClain — ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 25 29284 — State of Idaho BOARD OF HEALTH
Primary Registration District No. 2072 — Bureau of Vital Statistics
(No. ....., ... St.) — File No. 2
Registered No. 95
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of Am Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Myra Olive McAllister

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married

6. DATE OF BIRTH. April (Month) 30 (Day) 1877 (Year)

7. AGE 42 Yrs. 9 Mos. 22 ds. — IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Platteville Wis.

10. NAME OF FATHER Henry Sinton Wilson

11. BIRTHPLACE OF FATHER (State or Country) Not known.

12. MAIDEN NAME OF MOTHER Emily Lovejoy

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. F. McAllister
(Address) American Falls Ida.

15. Filed 3/10 1920 Richard T. Nott Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920 to Feb 22 1920 that I last saw her alive on Feb 22 1920 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH was as follows:
Influenza
Pneumonia
6 mos. pregnant
(Duration) Yrs. mos. 6 ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) Richard T Nott M. D.
3/10 1920 (Address) American Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Falls View Cemetery — **DATE OF BURIAL** 2/24 1920

20. UNDERTAKER A W Davis — **ADDRESS** Am Falls Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29285

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Avery
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 127
Primary Registration District No. 2400
File No. 1
Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Henry Reagy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. (Month) (Unknown) (Day) 1 (Year) 1873
7. AGE: 47 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Railway - Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Kansas
10. NAME OF FATHER: A. B. Reagy
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. L. Theriault R.N.C.O.
(Address) Avery - Idaho
15. Filed Feby 18 1920 (1917) C Busey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 18 (Day) 1920 (1917) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 13 1920 (1917), to February 18 1920 (1917), that I last saw him alive on February 18 1920 (1917), and that death occured on the date stated above, at 7:35 P. M.

The CAUSE OF DEATH* was as follows:
Uraemic Coma —
Chronic Interstitial Nephritis
(Duration) 1 Yrs. 4 mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. Busey M. D.
Feb 18 1920 (Address) Avery - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ellis Kansas
DATE OF BURIAL: Unknown 191

20. UNDERTAKER: H. E. Hunt
ADDRESS: St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29287

Registration District No. 137

Primary Registration District No. 2400

(No. ..... St.)

Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Avery

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Oscar Wiles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October (Month) 4 (Day) 1889 (Year)

7. AGE: Yrs. 30 Mos. 4 ds. 16

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Railway Car

(b) General nature of industry, business, or establishment in which employed (or employer): Repairer

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Samuel Wiles

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. R. O. Wiles

(Address) Avery, Idaho

15. Filed Feby 22d 1920 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 20 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 6 1920 to February 20 1920, that I last saw h[im] alive on February 20 1920, and that death occured on the date stated above, at 3.45 P.M.

The CAUSE OF DEATH* was as follows:

Influenza - Emphysema

Chronic Asthma

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary): Cardiac dilatation

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C O Bunn M. D.

2-22-1920 (Address) Avery Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash. DATE OF BURIAL: cremated Feb 23 1920

20. UNDERTAKER: H. E. Hunt ADDRESS: St. Maries Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1 29288

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Avery

Registration District No. 127

Primary Registration District No. 2400

(No. ..... St.)

2. FULL NAME William Edson Wood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October (Month) 21 (Day) 1882 (Year)

7. AGE: 37 Yrs. 3 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER James K. Wood

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. L. Wood per C.O.

(Address) Avery - Idaho

15. Filed Jan. 28 1920 191 C O Busey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 28 (Day) 1920 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 20 1920 191, to January 28 1920 191, that I last saw him alive on January 28 1920 191, and that death occured on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia - following influenza

(Duration) No Yrs. No mos. 8 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C O Busey M. D.

19..... (Address) Avery - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash. DATE OF BURIAL: Unknown 191

20. UNDERTAKER: Hunt ADDRESS: St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24853

Dr Mowery

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29289

Registered No. 17

Registration District No. 12

Primary Registration District No. 7190

1. PLACE OF DEATH.

County of Shoshone

City of Wallace (No. East Canyon Ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leonard Litten

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 13 (Day) 1918 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Wallace Ida

10. NAME OF FATHER: J K Litten

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Nora Norman

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J K Litten

(Address) Wallace Ida

15. Filed Jan 20 1920 H C Mowery Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1920, to Jan 16 1920, that I last saw him alive on Jan 16 1920 and that death occured on the date stated above, at 5A M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) H C Mowery M. D.

Jan 20 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Jany 18 1920

20. UNDERTAKER: R J Worden — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 127
Primary Registration District No. 2706
File No. 29290
Registered No. 18

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Red Cross Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucy Houck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... 1 (Day) ..... (Year)

7. AGE: 29 yrs. — mos. — ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housemaid
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: John Allen Lightbody

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Katie McGregor

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A.W. Lightbody
(Address) 467 Montgomery st Portland Ore

15. Filed 2/16 1920 H.C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 10 1920, to Feby 14 1920, that I last saw her alive on Feby 14 1920, and that death occurred on the date stated above, at 7:10 p M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

.....(Duration) ..... yrs. ..... mos. 5 ds.

Contributory (Secondary) Pregnancy

.....(Duration) ..... yrs. 4 mos. ..... ds.

(Signed) James R Beaw M. D.

Feby 16 1920 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence Pine Creek Idaho

19. PLACE OF BURIAL OR REMOVAL: Chippewa Falls Wis — DATE OF BURIAL: Feby 17 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 1-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2991
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 17
Primary Registration District No. 2700
(No. County Infirmary)

2. FULL NAME J. C. Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 46 Yrs. — Mos. — ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Rasmuss Larsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Kate Christensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Red Cross
(Address) Wallace

15. Filed 7/18 1920 H. C. Mowry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1920 to Feb 16 1920
that I last saw h. alive on Feb 16 1920
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) Influenza

(Duration) ..... mos. 4 ds.

7/18 1920 (Signed) Dr Mowry M. D.
(Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: San Francisco — DATE OF BURIAL: July 19 1920.

20. UNDERTAKER: Bruce J. Mortell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 17

Primary Registration District No. 2700

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29292

Registered No. 20

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Red Cross Hospital)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Richard Bryan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH
January 17th 1881
(Month) (Day) (Year)

7. AGE
39 yrs. 1 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Mill Forman
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Arkansas

10. NAME OF FATHER Thos. B. Bryan

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Harriet Frances Fyke

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maude Holt
(Address) Spokane Wn.

15.
Filed Feb 19 1920 H. C. Mowery
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb 17 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920 to Feb 17 1920 that I last saw him alive on Feb 17 1920 and that death occurred on the date stated above, at 6:5 P.M.

The CAUSE OF DEATH* was as follows:
Influenza - Pneumonia

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. L. Jennings M. D.
19 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State 7 yrs ..... mos ..... days.
Where was disease contracted if not at place of death? Kellogg Idaho
Former or usual residence Kellogg Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wn.	Friday 19 1920

20. UNDERTAKER	ADDRESS
B. G. Worstell By M Colehour	Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

AYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2706
File No. 29293
Registered No. 27

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.
(No. County Infirmary St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)
7. AGE: 68 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: housework
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wisconsin
10. NAME OF FATHER: not given
11. BIRTHPLACE OF FATHER (State or Country): not given
12. MAIDEN NAME OF MOTHER: not given
13. BIRTHPLACE OF MOTHER (State or Country): not given
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Ward
(Address) Wallace Ida
15. Filed 2/19 1920 H. C. Mower Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 17 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from January 1919, to Feby 17 1920, that I last saw h[illegible] alive on Feby 16 1920 and that death occurred on the date stated above, at 6:10 A.M.
The CAUSE OF DEATH* was as follows:
Acute Bronchitis
4
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Chr Rheumatoid Arthritis
(Duration) many yrs yrs. ..... mos. ..... ds.
(Signed) James R Brand M. D.
2/19 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Feby 21 1920
20. UNDERTAKER: Haney Thompson — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Burke
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122
Primary Registration District No. 2700
(No. Residence St.)

File No. 29294
Registered No. 22
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Toffe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word.): Married

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: 30 yrs. — mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Henry Olson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Mary Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Toffe
(Address) Burke Ida

15. Filed 2/18 1920 H. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. 17 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 12 1920, to Feb. 17 1920, that I last saw her alive on Feb. 17 1920 and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Influenza Pneumonia

(Duration) — yrs. — mos. 5 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) L. B. Stockwell M. D.
2/18 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Feby 20 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2100
File No. 29296
Registered No. 24

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Red Cross Hospital)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Guest Milionis

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 26 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sawmill man
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: John Milionis

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Parastrevo Lagios

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nicholas Arvas
(Address) Kellogg Idaho

15. Filed 2/20 1920 H. C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 20 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1920, to Feb 20 1920
that I last saw him alive on Feb 20 1920
and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) H. C. Mowery M. D.
2/20 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence Kellogg Idaho

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: Feby 21 1920

20. UNDERTAKER: Hans Thompson ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 12 7

Primary Registration District No. 2 700

File No. 29807

County of Shoshone

City of Gem (No. Residence St.)

Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Hicks

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: March (Month) 22 (Day) 1863 (Year)

7. AGE: 56 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: millman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas Hicks

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Granfell

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Harry Hicks
(Address) Gem Idaho

15. Filed 2/26 1920 H. C. McEvoy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 1910., to 2/23/20 191..., that I last saw h[illegible] alive on 2/23/20 about 2 191..., and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis - Myocarditis -

(Duration) Years yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 1 yrs. 4 mos. ..... ds.

(Signed) H. Merrill La Fevre M. D.

1924 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence Gem Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Feb 26 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 12 V 7 V 00

Primary Registration District No. 7 V 00

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29298

Registered No. 52

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Burke (No. Residence St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Philip Keefe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: January (Month) 1st. (Day) 1888 ~~1890~~ (Year)

7. AGE: ~~32~~ yrs. mos. 1 ds. 25 days

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Foundland

10. NAME OF FATHER: Thomas Keefe

11. BIRTHPLACE OF FATHER (State or Country): New Foundland

12. MAIDEN NAME OF MOTHER: Agnes Martin

13. BIRTHPLACE OF MOTHER (State or Country): New Foundland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Phil Keefe
(Address) Burke Idaho

15. Filed 2/28 1920 H. C. Moore Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~June~~ 1920, to Feb 25 1920, that I last saw h e alive on Feb 25 1920, and that death occurred on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) yrs. mos. 7 ds.

Contributory (Secondary) Pneumonia

(Duration) yrs. mos. 4 ds.

(Signed) Chas C Bell M. D.

2/28 1920 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida | DATE OF BURIAL: Feby 28 1920

20. UNDERTAKER: Harry Thompson | ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 12 vvo

Primary Registration District No. vvo

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29299

Registered No. 27

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. County Infirmary St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thelma Irene Lafon,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH. May (Month) 18th (Day) 1912 (Year)

7. AGE 7 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wellogg, Idaho.

10. NAME OF FATHER H.Carl Lafon

11. BIRTHPLACE OF FATHER Kansas (State or Country)

12. MAIDEN NAME OF MOTHER Alice Knapp

13. BIRTHPLACE OF MOTHER Kansas (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H C Lafon

(Address) Murray Ida

15. Filed 2/27 1920 H.C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 24th 1920, to 2/27 1920, that I last saw her alive on 2/26 1920 and that death occured on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James A Braw M. D.

2/27 1920 (Address) Wallace, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wallace, Idaho — DATE OF BURIAL Feby 29 1920

20. UNDERTAKER Bruce G Worstell. — ADDRESS Wallace, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29300

Registered No. 28

1. PLACE OF DEATH.

Registration District No. 12

Primary Registration District No. 1200

County of Shoshone

City of Wallace (No. Isolation Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Percy Claud Moe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 26 (Day) 1896 (Year)

7. AGE: 23 Yrs. 7 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E. L. Moe

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Lena Short

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ivan Buggs.

(Address) Wallace Idaho

15. Filed 3/1 1920

H. C. Mowry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 14 1920, to Feby 29 1920, that I last saw him alive on Feby 28 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenzal pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Influenza

(Duration ..... yrs. ..... mos. 8 ds.

(Signed) James A. Brann M. D.

2/29 1920 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Medimont Id

DATE OF BURIAL: 3/1 1920

20. UNDERTAKER: H. E. Morstell

ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-[illegible]

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29301
Registered No. 27

1. PLACE OF DEATH
Registration District No. 1 V 2
Primary Registration District No. 2700
County of Shoshone
City of Wallace
(No. R. F. D., Street or Hospital)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eli Durtoman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. July (Month) 15 (Day) 1882 (Year)
7. AGE 38 Yrs. 7 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Finland
10. NAME OF FATHER: not given
11. BIRTHPLACE OF FATHER (State or Country): " "
12. MAIDEN NAME OF MOTHER: not given
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ivan Boggs
(Address) Wallace Ida
15. Filed 2/29 1920 H C Moore Local Registrar

SVMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Feb 29 1920, that I last saw h[illegible] alive on Feb 28 1920, and that death occured on the date stated above, at 2:30 A.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. L. Jones M. D.
19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Enaville Ida
DATE OF BURIAL: 3/2 1920
UNDERTAKER: Bruce Moretti
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1W3
Primary Registration District No. 7701
Bureau of Vital ...
File No. 89302
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert M. Shaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Feb. (Month) 15 (Day) 1870 (Year)
7. AGE ..... Yrs. ..... Mos. 1 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Kellogg
10. NAME OF FATHER: Robt. M. Shaw
11. BIRTHPLACE OF FATHER (State or Country): Wash.
12. MAIDEN NAME OF MOTHER: Belle Smith
13. BIRTHPLACE OF MOTHER (State or Country): Wis
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. M. Shaw
(Address) Kellogg
15. Filed 1/20 1920 Geo. S. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 16 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 2/16 1920, to 2/16 1920, that I last saw him alive on 2/16 1920 and that death occured on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... Yrs. ..... mos. ..... ds.
(Signed) Geo. S. Lesher M. D.
2/20 1920 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg	2/17 1920
20. UNDERTAKER	ADDRESS
M. C. Thornhill	Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 28303

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
(No. ..... , ... St.)
Registration District No. 123
Primary Registration District No. 2 2 6 1
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Franklin Burt Ashby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Oct (Month) 12 (Day) 1884 (Year)

7. AGE
35 yrs. 5 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Engineer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Wm Ashby

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Hannah Pascal

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mabel Flock
(Address) Kellogg Idaho

15.
Filed 2/19 1920 Geo. S. Leahy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920 to Feb 16 1920 that I last saw him alive on Feb 16, 1920 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Influenza
.....
.....
(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary) Broncho Pneumonia
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) C. E. Handy M. D.
Feb 19 1920 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Coeur d'Alene Idaho	Feb 20 1920

20. UNDERTAKER	ADDRESS
M. L. Morrison	Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2304
Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 173
Primary Registration District No. 7701
(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

FULL NAME Sophia Kelley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	White	Married

6. DATE OF BIRTH
Feb (Month) 6 (Day) 1889 (Year)

7. AGE
31 yrs. 0 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER N. F. Peterson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Sophia Lundberg

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. M. Lambert
(Address) Spokane

15.
Filed 1/27 1920 Geo. S. Fesler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920, to Feb 25 1920
that I last saw her alive on Feb 24 191
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Influenza, followed by Myocarditis & Contributed by Thrombosis in legs & right arm
(Duration) yrs. mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo. S. Fesler M. D.
1/27 1920 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Graham, Wash. DATE OF BURIAL: 191

20. UNDERTAKER: M C Shankle ADDRESS: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29805
Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 173
Primary Registration District No. 7701
(No. , St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Boyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: June 1st (Month) (Day) 1843 (Year)
7. AGE: 76 yrs. 8 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Trinto Canada
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country): Irland
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country): Scotland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Emma Lemeyeaux
(Address) 116 Mullan St Kellogg Ida
15.
Filed 1/28 1912 Geo S Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 18 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 17th 1920, to Feb 17 1920
that I last saw him alive on Feb 17 1920
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows: Pneumonia Following Influenza
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Geo S Lesher M. D.
1/28 1920 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Keeney Idaho. DATE OF BURIAL: Feb 20 1920
20. UNDERTAKER: M C Shuerkel ADDRESS: Keeney Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS... CO

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 143
Primary Registration District No. 7701
File No. 1329306
County of Shoshone
City of Kellogg (No. ....., ... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Helen Clair McIntosh
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June 18 (Month) 1 (Day) 1845 (Year)

7. AGE: 33 yrs. 7 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: W. P. Shull

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Etta Conley

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. P. Shull
(Address) Spokane Wn.

15. Filed 2/28 1920 Geo S Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11, 1920, to Feb 17 1920 that I last saw her alive on Feb 17 1920 and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Influenzal Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Lindsay M. D.
2/19 1920 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn. | DATE OF BURIAL: 2/19 1920

20. UNDERTAKER: M. C. Thomkins | ADDRESS: Kellogg Ida.

BYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No. 2201
File No. 15 29307
Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lawrence Cecil Gibson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov 14 1902 (Month) (Day) (Year)

7. AGE: 17 yrs. 3 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Smelterman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: A. D. Gibson

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Ida May Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. D. Gibson
(Address) Kellogg Idaho

15.
Filed 2/28 1920 Geo. L. Leshe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. 19 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 19 1920 to Feb. 19 1920, that I last saw him alive on Feb 19 1920 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Influenza and Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. B. Lundy D.C. M. D.
2/28 1920 (Address) Wallace,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho DATE OF BURIAL: 2/21/1920

20. UNDERTAKER: M. C. Thomkins ADDRESS: Kellogg Ida.

SYMS - YORK CO., PTRS. & PUBS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1 1 3
Primary Registration District No. 1 1 0 1
File No. 16 9308
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Randolf Locke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January (Month) 16 (Day) 1877 (Year)

7. AGE: 43 yrs. 1 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: James Coleman Locke

11. BIRTHPLACE OF FATHER (State or Country): No Inf.

12. MAIDEN NAME OF MOTHER: Anne E. Beckman

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Locke
(Address) Kellogg Idaho

15.
Filed 1/28 1920 Jos. L. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1919 to Jan 19 1920, that I last saw him alive on Jan 19 1920, and that death occurred on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:
Influenza & Pneumonia

(Duration) ..... yrs. ..... mos. 9 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H B Lindsay M. D.
Jan 20 1920 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls, Ida. | DATE OF BURIAL: Jan 22, 1920

20. UNDERTAKER: M. C. Thomkins | ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Kellogg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123

Primary Registration District No. 7701

(No. .... St.)

File No. 29309

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Jane Schrupler

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Aug (Month) 22 (Day) 1841 (Year)

7. AGE: 78 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: E. R. Lloyd

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Do not know

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. L. Schrupler

(Address) Wenatchee, Wash.

15. Filed Jan 14 1920 Geo. A. Lesher Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 8 1920, to Jany 12 1920, that I last saw her alive on Jany 12 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

General debility

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Mason M. D.

1/14 1920 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Second Lane City. DATE OF BURIAL: Jan 15 1920

20. UNDERTAKER: M. C. Thornhill ADDRESS: Kellogg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29310

Registered No. .....

1. PLACE OF DEATH.

County of Shoshone

City of Kellogg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12 3

Primary Registration District No. 2201

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christ Palukis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married (Write the word.)

6. DATE OF BIRTH. Dec (Month) 25 (Day) 1887 (Year)

7. AGE 32 Yrs. — Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sevediko, Doridos, Greece

10. NAME OF FATHER James A. Palukis

11. BIRTHPLACE OF FATHER (State or Country) Sevediko, Doridas, Greece

12. MAIDEN NAME OF MOTHER Mary Silahas

13. BIRTHPLACE OF MOTHER (State or Country) Sevediko, Doridas, Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 1/22 1920 Geo. D. Lesher Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental Killed in Bunker Hill Smelter. by lead falling on him

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) Geo. D. Lesher Coroner M. D.

1/22 1920 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg	1/22 1920
20. UNDERTAKER	ADDRESS
M. C. Thornhill	Kellogg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29311
Registered No. .....

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ....., ... St.)
Registration District No. 1V3
Primary Registration District No. 9V01
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ferdinand D. Klatt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Divorced

6. DATE OF BIRTH.
— (Month) — (Day) 1885 (Year)

7. AGE
34 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Louisiana

10. NAME OF FATHER x nil

11. BIRTHPLACE OF FATHER (State or Country) nil

12. MAIDEN NAME OF MOTHER nil

13. BIRTHPLACE OF MOTHER (State or Country) nil

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. F. Kalbfleisch
(Address) Spokane, Wash.

15. Filed 1/17 1920 Geo. S. Fisher Local Registrar

YORK CO. PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January (Month) 16 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental Killed on
Bunker Hill Smelter
Crushed by lead.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. S. Fisher M. D.
1/17 1920 (Address) Kellogg, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wash	June 18, 1920
20. UNDERTAKER	ADDRESS
M. C. Thornhill	Kellogg Ida

RESERVED FOR BINDING

UNFADING INK—THIS IS A PERMANENT RECORD.

CAUSE OF DEATH should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 17 29312

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2201

2. FULL NAME John Flaraca

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: April 10 1919 (Month) (Day) (Year)

7. AGE: ____ yrs. 10 mos. 19 ds. IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ____
(b) General nature of industry business, or dstablishment in which employed (or employer) ____

9. BIRTHPLACE (State or Country) Kellogg. Idaho.

10. NAME OF FATHER Tony Flaraca.

11. BIRTHPLACE OF FATHER (State or Country) Italy.

12. MAIDEN NAME OF MOTHER Cigne Crouse.

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Vito Rubino
(Address) Kellogg Idaho

15. Filed 3/5 1920 Geo. D. Lesker Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February 28 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1920 to Feb 28 1920 that I last saw him alive on Feb 28 1920 and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Whooping Cough
(Duration) ____ yrs. 1 mos. ____ ds.
Contributory (Secondary) Pneumonia
(Duration) ____ yrs. ____ mos. 6 ds.

(Signed) E. E. Hardy M. D.
Mar 3 1920 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Keery Idaho. DATE OF BURIAL: Mch 1 1920

20. UNDERTAKER: McShannon ADDRESS: Keery Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH 29313

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
(No. ..... St.)
File No. [illegible]
Registered No. .....

1. PLACE OF DEATH
County of Teton
City of Driggs
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mable Pearson Madsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	married

6. DATE OF BIRTH: October (Month) 18 (Day) 1888 (Year)

7. AGE: 32 Yrs. 3 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper.
(b) General nature of industry, business or establishment in which employed (or employer): "

9. BIRTHPLACE (State or Country): Pleas. Utah.

10. NAME OF FATHER: Niles Pearson.

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Rebecca Casper.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Madsen
(Address) Driggs, Idaho

15. Filed Feb 15th 1920 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1920, to Feb 10 1920, that I last saw h[illegible] alive on Feb 10 1920 and that death occurred on the date stated above, at 4:45 P M.
The CAUSE OF DEATH* was as follows:
Pulmonary
Terminal Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary) Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. E. Culbertson M. D.
2-14 1920 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Driggs cemetery	Feb 13 1920

20. UNDERTAKER	ADDRESS
W Thurman	Ashton, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
The information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N. B.—Every item

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29314 State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

File No. Sing

Registered No. .....

1. PLACE OF DEATH.

County of Teton

City of Tetonia

Registration District No. 77

Primary Registration District No. 2176

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melissa Wardle Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. May (Month) 23 (Day) 1919 (Year)

7. AGE: ....Yrs. 9 Mos. ....ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Milton W. Thompson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary A. Wardle

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie L Wardle

(Address) Victor Idaho

15.

Filed March 1st 1920 Martha Marker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb- 20 1920, to Feb- 23 1920, that I last saw him alive on Feb-20- 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

.....(Duration) ....Yrs. ....mos. 4 ds.

Contributory (Secondary) .....

.....(Duration ....yrs. ....mos. ....ds.

(Signed) H. H. Culbertson M. D.

19.... (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Tetonia Idaho

DATE OF BURIAL: Feb 25 1920

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77 — 293

Primary Registration District No. 2176

File No. Eight

Registered No. .....

1. PLACE OF DEATH.

County of Teton

City of Victor (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Odessa Bergen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. 9th (Month) (Day) 1883 (Year)

7. AGE: 37 Yrs. 4 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Frank Parsons.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Leona Curtis

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Bergen

(Address) Victor, Ida.

15. Filed March 3rd 1920 — Martha Marker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr 4 1920, to Febr 14 1920, that I last saw h.. alive on Febr 14 1920, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Complicating Influenza.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Clark, M. D.

19..... (Address) Driggs, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor Idaho — DATE OF BURIAL: Feb 16 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29316 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Teton
City of Victor

Registration District No. 77
Primary Registration District No. 2176
(No. .... St.)
File No. Sexton
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann (Parsons) Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.): Married

6. DATE OF BIRTH. June 22 (Month) (Day) 1889 (Year)

7. AGE: 30 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Teton County Idaho

10. NAME OF FATHER: Frank Parsons

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Leona Curtis

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James L. Brinton
(Address) Victor Ida

15.
Filed March 1st 1920 191.....
Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr 6 1920, to Febr 6th 1920, that I last saw h[illegible] alive on Febr 6 1920, and that death occured on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia & Influenza
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Thos. J. Martin M. D.
19..... (Address) Victor, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Victor Idaho. DATE OF BURIAL: Feb 8 1920

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRON - YORK CO., PTRS. & BKBS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29317

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77

Primary Registration District No. 2176

File No. Nine

Registered No. .....

1. PLACE OF DEATH.

County of Teton

City of Victor

If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Florence Marguerite Jenkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct Feb 11 14 1918 20
(Month) (Day) (Year)

7. AGE: 1 Yrs. 4 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Teton Idaho

10. NAME OF FATHER W Raymond Jenkins

11. BIRTHPLACE OF FATHER (State or Country) Sandy Vt.

12. MAIDEN NAME OF MOTHER Ellen Elizabeth Best

13. BIRTHPLACE OF MOTHER (State or Country) Tonganth Vt.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs W Bennett
(Address) Victor Ida.

15.
Filed March 3rd 1920 Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 14 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr 7 1920, to Febr 14 1920, that I last saw her alive on Febr 14 1920 and that death occured on the date stated above, at 3 0' M.

The CAUSE OF DEATH* was as follows:
Pneumonia Complicating Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Martin M. D.

19..... (Address) Driggs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor Idaho

DATE OF BURIAL: Feb. 15 1920

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29318

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Teton.

City of Victor

(No. ..... St.)

Registration District No. 77

Primary Registration District No. 2176

File No. Ten.

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence Dermont Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 13 (Day) 1892 (Year)

7. AGE: 27 Yrs. 11 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph Johnson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Ruth A. Albertson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Johnson

(Address) Victor, Idaho

15.

Filed March 3rd 1920 Martha Marker Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1920, to Feb 12 1920, that I last saw h[illegible] alive on Feb 12 1920 and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Complicating Influenza.

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Martin M. D.

19..... (Address) Victor, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Victor Idaho

DATE OF BURIAL: Feb 14th 1920

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 36

Primary Registration District No.

2931 State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

File No.

Registered No. 9

1. PLACE OF DEATH.

County of Twin Falls

City of Hansen (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nancy Lynch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Apr (Month) 12 (Day) 1824 (Year)

7. AGE: 95 yrs. 10 mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: — Lynch

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. J. Lynch

(Address) Hansen

15. Filed Feb-13 1920 J. P. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on Feb 11 1920,

and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Senile Marasmus

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Davis M. D.

2/13 1920 (Address) Hansen

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer, Idaho — DATE OF BURIAL: 2/14 1920

20. UNDERTAKER: C. J. Grossman — ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19780

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
(No. ..... St.)

File No. 29320
Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls
City of Kimberly

2. FULL NAME Mary Simmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July 31 1
(Month) (Day) (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ark

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred Trueblood
(Address) Kimberly Idaho

15. Filed Feb 10 1920 J M Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 9 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr 1920 to Feb 9 1920
that I last saw h alive on Feb 9 1920
and that death occured on the date stated above, at [redacted].

The CAUSE OF DEATH* was as follows: Carcinoma of liver.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Sweetser M. D.
19..... (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls, Ida — DATE OF BURIAL: 2-11-1920

20. UNDERTAKER: J. E. Debrett — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH,
Bureau of Vital Statistics

23851

1. PLACE OF DEATH.
County of Twin Falls
City of Hansen
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36
Primary Registration District No.
(No. ....., ... St.)

File No.
Registered No. 4
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane Frances Pollock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: w
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) - 29 (Day) 1889 (Year)

7. AGE: 30 yrs. 7 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: O. M. Etter

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary A Lee

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs O M Etter
(Address): Twin Falls Idaho

15.
Filed Feb 10 1920 J M Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb (Month) - 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920, to Feb 9 1920, that I last saw h alive on Feb 9 1920 and that death occurred on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary): Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Davis M. D.
2/10 1920 (Address) Kimberly Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 2-12 1920

20. UNDERTAKER: J. A. Merritt
ADDRESS: T F

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29322
Registered No. 5

1. PLACE OF DEATH
County of Twin Falls
City of Shimbler
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Diver James Brendan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	White	Married

6. DATE OF BIRTH. Feb. 3 (Month) (Day) 1920 (Year)

7. AGE .....Yrs. .....Mos. 4 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Shimbler

10. NAME OF FATHER W. D. Brendan

11. BIRTHPLACE OF FATHER (State or Country) [redacted] Missouri

12. MAIDEN NAME OF MOTHER Lula J Lussey

13. BIRTHPLACE OF MOTHER (State or Country) Indian Ter

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Lussey
(Address) .....

15. Filed 2/8 1920 J M Davis
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 7 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1920 to Feb 7 1920
that I last saw h[redacted] alive on Feb 6 1920
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Asthenia Neonatorum
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J M Davis M. D.
2/8 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Idaho — **DATE OF BURIAL** 1-[redacted]8 1920

20. UNDERTAKER F E Everett — **ADDRESS** Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 36

City of Kimberly — Primary Registration District No.

(No. ..... St.)

File No. 29324

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Dec. (Month) 8 (Day) 19[illegible] (Year)

7. AGE: 11 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) Rancher

9. BIRTHPLACE (State or Country) Nebr

10. NAME OF FATHER A. H. Brown

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Edith Brewer

13. BIRTHPLACE OF MOTHER (State or Country) Ia.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. E. Brown

(Address) Kimberly

15. Filed Feb. 23 1920 — J. N. Davis, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920 to Feb. 23 1920 that I last saw her alive on Feb. 22 1920 and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cerebro Spinal Meningitis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J. N. Davis M. D.

2/23 1920 (Address) Kimberly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. J. Grossman — ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29325
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Hansen
(No. ....., ... St.)
Registration District No. 27
Primary Registration District No. 2085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Vanderpool

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb 24 (Month) (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 12 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Hansen

10. NAME OF FATHER R H Vanderpool

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Adsdown

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R H Vanderpool
(Address) Twin Falls

15. Filed Feb 29 1920 John F Cawthon Local Registrar

SYMS - YORK CO., PTRS. & BOXS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 25 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-24 1920, to 2-25 1920, that I last saw him alive on 2-24 1920, and that death occured on the date stated above, at 12.25 PM.

The CAUSE OF DEATH* was as follows:
Premature

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia Acute failed to Close

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Stafford M. D.
2-25 1920 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Feb 25 1920

20. UNDERTAKER: F E Stewart — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of Buhl — Primary Registration District No. 2085

(No. ....., ... St.)

File No. 29326

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Edwards

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Dont Know (Month) (Day) (Year)

7. AGE: 42 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. P. Grossman

(Address) Twin Falls

15. Filed Feb 25 19 20 John T. Caughlan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 26 (Day) 20 (Year) 1920

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 9:P M.

The CAUSE OF DEATH* was as follows:

Revolver Wound of neck and Abdomen. (Homicidal)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Grossman M.D.

2/23 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: 2/24 1920

20. UNDERTAKER: J. P. Grossman

ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29327

Registered No.

1. **PLACE OF DEATH**

County of Jerome

City of Eden

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 2085

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elting Barnes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1[illegible] (Year)

7. AGE: ..... Yrs. ..... Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Eden Idaho

10. NAME OF FATHER C. E. Barnes

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER [illegible]

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. E. Barnes

(Address) [illegible]

15. Filed Feb 6 1920 John F. Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/29 1920 to 2/3 1920 that I last saw him alive on 2/3 1920 and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Pneumonia.

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Dr. P. Scroggs M. D.

19..... (Address) Eden, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Cem — DATE OF BURIAL: Feb 4 1920

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29328
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Berger
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085
(No. ..... St.)

2. FULL NAME Bertha R Galbraith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Aug (Month) 9 (Day) 1 (Year)

7. AGE
26 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) New Mexico

10. NAME OF FATHER
D C. Crowell

11. BIRTHPLACE OF FATHER
(State or Country) Tenn

12. MAIDEN NAME OF MOTHER
Mary L Fronton

13. BIRTHPLACE OF MOTHER
(State or Country) New Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Garfield Galbraith
(Address) Berger

15.
Filed Mar 3 1920 John L Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920, to Feb 25 1920, that I last saw h alive on Feb 24 1920, and that death occured on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 5 ds.
(Signed) C. A. Weaver M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 2-27-1920

20. UNDERTAKER: L E Dewitt — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29329
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Mar 22 (Month) (Day) 1900 (Year)

7. AGE
19 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER: John B Davis

11. BIRTHPLACE OF FATHER
(State or Country) Newyork

12. MAIDEN NAME OF MOTHER: Mira ackerley

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John B. Davis
(Address) Rogerson Ida.

15.
Filed Mar 1 1920 John Laughlin Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 24 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920, to Feb 24 1920, that I last saw h~~im~~ alive on Feb 23 1920, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.

(Signed) Dr John F Laughlin M. D.
2/23 19..... (Address) Twin Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Feb 26 1920

20. UNDERTAKER: L E Elliott — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29350

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 1085

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hans Hansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mak

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Dont Know (Month) ..... (Day) ..... (Year)

7. AGE: 60 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew A Hansen
(Address) Twin Falls

15. Filed Mar 1 1920 John F Cauchlis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Cardiac Regurgitation

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. C. McGinnis M. D.

2/28 1920 (Address) 310 3rd Ave. N. Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: 2/29 1920

20. UNDERTAKER: J. P. Grossman | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—26 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29331

Registered No.

1. PLACE OF DEATH
County of Twin Falls Registration District No. 27
Primary Registration District No. 1082
City of [illegible] (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. Brown
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: dont know (Month) (Day) (Year)

7. AGE: 53 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Grossman
(Address) Twin Falls Ida.

15. Filed Feb 29 1920 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1920 to Feb 26 1920
that I last saw him alive on Feb 26 1920
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Carcinoma

(Duration) 2 Yrs. ——— mos. ——— ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. C. D. McGinnis M.D.
2/27 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 23 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Jarbidge Nev.

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: Feb 28 1920

20. UNDERTAKER: J. J. Grossman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 1085
File No. 29332
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of [illegible]
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah C. Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: Oct. (Month) 17 (Day) 1847 (Year)

7. AGE: 72 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Work Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Bridger

11. BIRTHPLACE OF FATHER (State or Country): [illegible]

12. MAIDEN NAME OF MOTHER: Ruth Bridger

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank B Thompson
(Address) Twin Falls Ida

15. Filed Feb 25 1920 John F Caughlan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1920 to Feb 23 1920 that I last saw her alive on Feb 2 1920 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Acute dilatation Heart
.....
.....
.....(Duration) Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
.....(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Duncan L Bryant M. D.
2/24 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Creston Iowa
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. P. Goodman
ADDRESS Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 29333
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Feb 16 (Month) (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L C Cox

11. BIRTHPLACE OF FATHER (State or Country) Texas

12. MAIDEN NAME OF MOTHER Ora Smith

13. BIRTHPLACE OF MOTHER (State or Country) Okla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L C Cox
(Address) Twin Falls

15. Filed Feb 20 1920 John H Vaughn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 19 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 16 1920, to Feb. 19 1920, that I last saw he alive on Feb. 18 1920, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Apen foramen ovale.

(Duration) 0 Yrs. 0 mos. 3 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E Owen Cox M. D.
2-20 1920 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Idaho — DATE OF BURIAL 2-20 1920

20. UNDERTAKER E E Wood — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29334
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 37
Primary Registration District No. 1083
(No. ..... St.)

2. FULL NAME Wesley Melton Burgess

(If death occurred in a hospital, institution or camp, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. March 30 (Month) (Day) 1889 (Year)
7. AGE: 37 Yrs. 10 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country) Maine
10. NAME OF FATHER James Burgess
11. BIRTHPLACE OF FATHER (State or Country) Wis
12. MAIDEN NAME OF MOTHER Mary Rearick
13. BIRTHPLACE OF MOTHER (State or Country) Ind
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C.W. Peck
(Address) Hazelton, Ida
15. Filed Feb 23 1926 John F. Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 20 (Month) (Day) 1926 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Over dose of a proprietory medicine (Accidental)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. J. Grossman Coroner
2/23 1926 (Address) Twin Falls Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hazelton Idaho — DATE OF BURIAL: Feb 25 1926
20. UNDERTAKER: J.C. Records — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 29335

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ..... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Conant

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. July (Month) 15 (Day) 1869 (Year)

7. AGE: 56 Yrs. 5 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER Frank Ferguson

11. BIRTHPLACE OF FATHER
(State or Country) not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C H Robinson
(Address) Canal Front Idaho

15. Filed Feb 20 1920 John F Caughlin Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920, to Feb 18 1920, that I last saw h[illegible] alive on Feb 18 1920, and that death occured on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:
Uremia primary Cause not known

.....(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J H Byrd M. D.
Feb 20 1920 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idah — DATE OF BURIAL: Feb 20 1920

20. UNDERTAKER: [illegible] — ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29336
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 1085

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Humphries

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH.
Aug (Month) 15 (Day) 1889 (Year)

7. AGE
30 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) MO

10. NAME OF FATHER: Frank Kimble

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER: Emma Lewis

13. BIRTHPLACE OF MOTHER
(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Levi Fralick
(Address) J. M. Humphries

15.
Filed Feb 20 1920
John F. Caughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1920, to Feb 19 1920,
that I last saw her alive on Feb 20 1920,
and that death occured on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Influenza Pulmonary Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 12 ds.
(Signed) F. A Duerte M. D.
2-20 1920 (Address) Filer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 12 days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boswarth MO
DATE OF BURIAL 191

20. UNDERTAKER: J. E. De Witt
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29337
Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of .....

(No. ..... St.)

Registration District No. 37

Primary Registration District No. 1082

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucill Dorthy Owens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. June 23 (Month) (Day) 1918 (Year)

7. AGE: ..... Yrs. 8 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Okla

10. NAME OF FATHER: C M Owens

11. BIRTHPLACE OF FATHER (State or Country): Ark

12. MAIDEN NAME OF MOTHER: Mable Lamon

13. BIRTHPLACE OF MOTHER (State or Country): Okla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. M. Owens

(Address) Twin Falls

15. Filed Feb. 18 1920 John F. Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920, to Feb 16 1920, that I last saw her alive on Feb 16 1920, and that death occured on the date stated above, at 7:22 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Influenza

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Slaught M. D.

Feb 16 1920 (Address) Twin Falls, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Carnegie Okla — DATE OF BURIAL ..... 191...

20. UNDERTAKER: J E Dewitt — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29338

Registered No. .....

1. PLACE OF DEATH.

County of Twinfalls

City of Twinfalls

(No. ....., ... St.)

Registration District No. 37

Primary Registration District No. 1085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Enos Ingle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April 14 (Month) (Day) 1 (Year)

7. AGE: 81 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ohio

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Twin Falls

(Address) R. F. D. Ingle

15. Filed Feb 18 1920 John F. Cauchy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 17 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920, to Feb 17 1920, that I last saw h in alive on Feb 17 1920, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Lloyd M. D.

Feb 17 1920 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 2-18 1920

20. UNDERTAKER: J. E. Dewitt — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 29339
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert E. Putnam
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: August 7 (Month) (Day) 1912 (Year)

7. AGE: 7 Yrs. 6 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer): Rancher

9. BIRTHPLACE (State or Country): Nebr.

10. NAME OF FATHER: Harry J. Putnam

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Elizabeth Lahende

13. BIRTHPLACE OF MOTHER (State or Country): Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Johnson Putnam
(Address) Twin Falls

15. Filed Feb 18 1920 John F. Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 5108

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 15 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1920 to Feb 15 1920
that I last saw h.. alive on Feb 15 1920
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Lauchert M. D.
Feb 15 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 2/17 1920

20. UNDERTAKER: J. J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

City of [illegible] Primary Registration District No. 1082

(No. ..... St.)

File No. 29340

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter J. Pettitt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: May 11 1891
(Month) (Day) (Year)

7. AGE: 28 Yrs. 9 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John W. Pettitt

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Elnora J. Miller

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Walter J. Pettitt
(Address) Twin Falls Idaho

15. Filed Feb 18 1920 John H Cavellio
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 14 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920 to Feb. 14 1920
that I last saw h[illegible] alive on 11 13 1920
and that death occurred on the date stated above, at 4:30 A M.
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Morgan M. D.
Feb 15 1920 (Address) Twin Falls. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Topeka Kans. DATE OF BURIAL: 2/16 1920

20. UNDERTAKER: O. J. Grosenick ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 2344

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Twin Falls
City of .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lola May Mills

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
aug (Month) 2 (Day) 1 (Year)

7. AGE
57 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Mike Brockett

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clyde W. Mills
(Address) Twin Falls, Ida.

15.
Filed Feb 16 1920 John F. Caughlin Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 5 1920, to February 12 1920, that I last saw her alive on February 12, 1920, and that death occured on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, lobular.

(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) Cardiac Failure.
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) M. F. Passer, M. D.
Feb 16, 1920 (Address) Rfd Annis, Twin Falls, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 7 ...days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? 312 - 5th N.
Former or usual residence 312 - 5th N.

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho
DATE OF BURIAL: Feb 14 1920

20. UNDERTAKER: Ed Scott
ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 29342
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Brentan

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M Wid C

6. DATE OF BIRTH.
aug 28 (Month) (Day) 1900 (Year)

7. AGE
20 Yrs. 5 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House work
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Calo

10. NAME OF FATHER
Benjamin Pedego

11. BIRTHPLACE OF FATHER
(State or Country) MO

12. MAIDEN NAME OF MOTHER
myrtle wheeler

13. BIRTHPLACE OF MOTHER
(State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. N. Pedego
(Address) Twin Falls

15.
Filed Feb 14 1920 John F. Caughlin Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1920, to Feb 12 1920, that I last saw h[illegible] alive on Feb 12 1920, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Lauchert M. D.
2/12 1920 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho
DATE OF BURIAL: 2-13 1920

20. UNDERTAKER: J E Dearth
ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29343
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Twin Falls
City of ..... (If not in limits, write "Not")
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. .... St.)

2. FULL NAME Geneavra Newman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): X

6. DATE OF BIRTH.
Mar. 9 1
(Month) (Day) (Year)

7. AGE
2 Yrs. 11 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Stockman

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER S. O. Newman

11. BIRTHPLACE OF FATHER
(State or Country) Iowa

12. MAIDEN NAME OF MOTHER Julia A. Jones

13. BIRTHPLACE OF MOTHER
(State or Country) Kent.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. O. Newman
(Address) Twin Falls Ida

15.
Filed Feb 16 1920 John F. Caughlin
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 7 1920, to Feb. 13 1920, that I last saw h[er] alive on Feb 13 1920, and that death occured on the date stated above, at 10:50A M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Meningitis
(Duration ..... yrs. ..... mos. 1 ds.
(Signed) John H Caughlin M. D.
2-13 1920 (Address) Twin Falls Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. — DATE OF BURIAL: Feb. 14 1920

20. UNDERTAKER: J. E. DeWitt — ADDRESS: Twin Falls

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29344
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellis Harley Skinner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. April 16 1919
(Month) (Day) (Year)

7. AGE ..... Yrs. 9 Mos. 21 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Twin Falls

10. NAME OF FATHER Brigham Skinner

11. BIRTHPLACE OF FATHER (State or Country) Boria Idaho

12. MAIDEN NAME OF MOTHER Alice Harley

13. BIRTHPLACE OF MOTHER (State or Country) Soda Springs

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Brigham Skinner
(Address) Twin Falls Idaho

15. Filed Feb 13 1920 John H Caughlan
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 7 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920 to Feb 6 1920
that I last saw h.. alive on Feb 6 1920
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia
.....
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) T S Morgan M. D.
Feb 9 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Idaho — DATE OF BURIAL Feb 9 1920

20. UNDERTAKER J E Jewett — ADDRESS Twin Falls

N. B.—Every item of information should be carefully and fully answered, so that it may be properly classified. Write plainly, with unfading ink. Do not abbreviate. Use figures for dates. Do not use ditto marks. See instructions on back of certificate. Cause of death should be certified in plain terms, so that it may be properly classified. See instructions on back of certificate. The space for OCCUPATION is very important.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of ( )
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 29345
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Merl Smyth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Nov 7 (Month) (Day) 1919 (Year)

7. AGE: 2 Yrs. 2 Mos. 23 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Smyth

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Gertrude Smith

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): William Smyth
(Address): Twin Falls

15. Filed Feb 3 1920 John F. Cavanaugh Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 1 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920 to Feb 1 1920 that I last saw h. alive on Jan 31 1920, and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows: Pneumonia — Lobular

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jas. A. Hughes M. D.
2-3 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 2-5 1920

20. UNDERTAKER: J. E. Ewell
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29346
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

2. FULL NAME Maxine Booth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH.
August 5 1918
(Month) (Day) (Year)

7. AGE
1 Yrs. 6 Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Lester Booth

11. BIRTHPLACE OF FATHER
(State or Country) Denmark

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed Feb 10 1920 John F. Caughlin
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7th 1920 to Feb 8th 1920
that I last saw h.. alive on Feb 8th 1920
and that death occurred on the date stated above, at 8.20 A.M.

The CAUSE OF DEATH* was as follows:
Influenza
.....
.....
.....(Duration) ..... Yrs..... mos. 5 ds.
Contributory (Secondary) Broncho Pneumonia
.....(Duration) ..... Yrs..... mos. 2 ds.
(Signed) C. W. McGinnis M. D.
2/9 1920 (Address) 310 3rd Ave N. Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Idaho — DATE OF BURIAL Feb 9 1920

20. UNDERTAKER L E Elwood — ADDRESS Twin Falls

A. B. Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29347
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 1085
(No. ....., ... St.)

2. FULL NAME Laura May Baath

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 1 (Month) (Day) (Year)

7. AGE: 34 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Mount Pilot Idaho

10. NAME OF FATHER: Peter Sorensen

11. BIRTHPLACE OF FATHER (State or Country): Denkmark

12. MAIDEN NAME OF MOTHER: Marget Jansen

13. BIRTHPLACE OF MOTHER (State or Country): Mount Pilot Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. P. Sorensen
(Address) Twin Falls, Ida.

15. Filed Feb 10 1920 John F. Caughlin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 8 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1920 to Feb 8 1920 that I last saw her alive on Feb 7 1920 and that death occurred on the date stated above, at 4 A M.
Feb 8th

The CAUSE OF DEATH* was as follows:
Influenza
.....
.....
.....(Duration) ..... Yrs. ..... mos. 7 ..... ds.
Contributory (Secondary) Broncho Pneumonia
.....(Duration) ..... Yrs. ..... mos. 3 ..... ds.
(Signed) O. M. Gunning M. D.
2/9 1920 (Address) 310 3rd Av W Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Feb 10 1920

20. UNDERTAKER: J. E. Newell — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29348
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 10.8.5
(No. ....., ... St.)

2. FULL NAME Geo Miller Dow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July 11 1
(Month) (Day) (Year)

7. AGE: 34 Yrs. 6 Mos. 23 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Worthy L. Dow

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Rose Sulsmans

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Etta L. Dow
(Address) 1061 Eden St. Twin Falls

15. Filed Feb. 6 1920 John H. Caughlin Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 4 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 29 1920 to Feb 4 1920
that I last saw h.... alive on Feb 4 1920.
and that death occurred on the date stated above, at 10 ..M.

The CAUSE OF DEATH* was as follows:
Gall stones
.....
.....
.....(Duration) ..... Yrs..... mos..... ds.
Contributory (Secondary) Operation — Surgical Shock
.....(Duration) ..... Yrs..... mos..... ds.
(Signed) ..... M. D.
Feb 6 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 1-8 1920

20. UNDERTAKER: L. E. Verett — ADDRESS: Twin Falls

DEATH in plain terms, so that it may be properly classified. Exact statement
OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of ( ) — Primary Registration District No. 1085 — File No. 29349

(No. ..... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ann Lowry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: June 15 (Month) (Day) 1839 (Year)

7. AGE: 80 Yrs. 8 Mos. 13 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework (retired)

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Bradley

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: dont Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Lowry

(Address) Twin Falls

15. Filed Mar 2 1920 — John Laughlin — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 28 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19 1919, to Feb. 27 1920, that I last saw her alive on Feb. 20 1920, and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. 3 mos. ..... ds.

Contributory (Secondary): Paralysis Agitans

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Chas. R. Scott M. D.

3/1 1920 (Address) Twin Falls - Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 3/1 1920

20. UNDERTAKER: J. F. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 29350
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mattie O. Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. March (Month) 5 (Day) 1890 (Year)

7. AGE: 29 Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) wife

9. BIRTHPLACE (State or Country) Virginia

10. NAME OF FATHER Alex Porter

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Rose Cornett

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. P. [illegible]
(Address) R[illegible]worth

15. Filed Feb. 20 '20 191.... A. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-14 1920 to 2-18 1920 that I last saw her alive on 2-18 1920 and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Pleuro-Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Geo. Jennings M. D.
2-19 1920 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sec 2 Cemetery Filer — DATE OF BURIAL: Feb 20. 1920

20. UNDERTAKER: F E Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29351
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ann Bickford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Apr. (Month) 6 (Day) 1850 (Year)

7. AGE: 69 Yrs. 10 Mos. 28 ds.
IF LESS THAN 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) ..... wife

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Samuel Moore

11. BIRTHPLACE OF FATHER (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Barbry Jane Foster

13. BIRTHPLACE OF MOTHER (State or Country) Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D C Bickford
(Address) Filer

15. Filed Feb. 16 20 — A. A. Newberry, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 15 (Day) 20 (Year) 191...

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 20 191... to Feb 15 20 191...
that I last saw h[illegible] alive on Feb 15 191...
and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

.....(Duration) ..... Yrs..... mos..... ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs..... mos..... ds.

(Signed) A. A. Newberry M. D.
Feb. 15 20 19... (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sook Cemetery — DATE OF BURIAL Feb 17 1920

20. UNDERTAKER J E Dran — ADDRESS Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2952
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 28
Primary Registration District No. 7086
(No. ..... St.)

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eva Elizabeth Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F/W/M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1905 (Year)

7. AGE: 15 Yrs. 3 Mos. 3 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER E S Martin

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Rose Yoder

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E S Martin
(Address) .....

15. Filed Feb. 11 20 191.... A. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 10 (Day) 20 191.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191...
and that death occurred on the date stated above, at about 11 PM.

The CAUSE OF DEATH* was as follows:
Not known - was dead when I arrived.
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
Feb. 11. 19 20 (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ioof Cemetery — DATE OF BURIAL Feb. 12.. 1920

20. UNDERTAKER F E Drake — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 39

Primary Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29353

Registered No.

1. **PLACE OF DEATH**

County of Twin Falls

City of Buhl

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Margarett Egbert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.)
F.	White	Married

6. **DATE OF BIRTH** March 17 1882
(Month) (Day) (Year)

7. **AGE** 37 Yrs. 10 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Missouri

10. **NAME OF FATHER** Isaac Nanney

11. **BIRTHPLACE OF FATHER** (State or Country) Missouri

12. **MAIDEN NAME OF MOTHER** Nancy Ellis

13. **BIRTHPLACE OF MOTHER** (State or Country) Missouri

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) M. E. Egbert
(Address) Buhl

15. Filed Jan. 30 1920 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Jan. 27 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-20 1920, to 1-27 1920 that I last saw her alive on 1-27 1920 and that death occurred on the date stated above, at 12 — M. The CAUSE OF DEATH* was as follows:

Embolism - following surgical operation.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. E. Cummings M. D.

1/7/1920 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Buhl — **DATE OF BURIAL** Jan. 30 1920

20. **UNDERTAKER** Homer B. Evans — **ADDRESS** Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 34

Primary Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29354

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of Idaho.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Lesley Kirkbride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: July (Month) 3 (Day) 1918 (Year)

7. AGE: 1 Yrs. 6 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: J. L. Kirkbride

11. BIRTHPLACE OF FATHER (State or Country): Smithfield Utah

12. MAIDEN NAME OF MOTHER: Mary Jacobson

13. BIRTHPLACE OF MOTHER (State or Country): Huntington Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): J. L. Kirkbride

(Address):

15. Filed Jan 27 1920

J. H. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 22 1920 to Jan 26 1920 that I last saw him alive on Jan 26 1920 and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza. (Epidemic form)

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Hypostatic pneumonia

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) F. A. Irmen M. D.

Jan 28 1920 (Address) Buhl Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery.

DATE OF BURIAL: Jan 29 1920

20. UNDERTAKER: Neville D. Rugg.

ADDRESS: Buhl Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 39

Primary Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29355

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of Buhl. Ida

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Whitby.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ (never married)

6. DATE OF BIRTH: May 30 (Month) (Day) 1839 (Year)

7. AGE: 80 Yrs. 8 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ~~Miner~~ farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Robert Whitby

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cordelia E. Whitby

(Address) .....

15. Filed 1-10 1920 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-17 1919, to 1-9 1920 that I last saw h~~im~~. alive on 1-9 1920 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Jennings M. D.

1-10 1920 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Cemetery — DATE OF BURIAL: 1-11 1920

20. UNDERTAKER: J E Schmidt — ADDRESS: Buhl. Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29356
Registered No.

Registration District No. 34
Primary Registration District No. 2081
(No. ..... St.)

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Jackson Miller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: April (Month) 19 (Day) 1900 (Year)

7. AGE: 19 Yrs. 9 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Rud Miller

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Gertrude Nutter

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Viola Thatcher
(Address) Buhl - Ida.

15. Filed Feb-3 1920
J. H. Silvernail
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-31 1920 to 2-2- 1920 that I last saw h. alive on 2-2 1920, and that death occurred on the date stated above, at 7 a. M.
The CAUSE OF DEATH* was as follows:

Pleuro-Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Jenning M. D.
2-2 1920 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida.
DATE OF BURIAL: 2-3 1920

20. UNDERTAKER: Homer B Evans
ADDRESS: Buhl

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 39

Primary Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29357

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of Buhl

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wesley Monroe Piercy.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: March (Month) 2 (Day) 1875 (Year)

7. AGE: 44 Yrs. 11 Mos. 7 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Nute Piercy.

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Phoebe Jane Daniels

13. BIRTHPLACE OF MOTHER (State or Country): Kenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jason A. Bennett.

(Address) Buhl

15. Filed Feb. 11 1920

J. W. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-8- 1920 to 2-9- 1920 that I last saw h.. alive on 2-9- 1920 and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Frank Jennings M. D.

2-9 1920 (Address) Buhl Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: Feb 11 1920

20. UNDERTAKER: Neville & Rigg. — ADDRESS: Buhl Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 29358
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Meredith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Dont Know

6. DATE OF BIRTH: Dont Know (Month) (Day) 1 (Year)

7. AGE: about 40 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer): Laborer

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed Feb. 13 1920 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 27 1920, to February 10, 1920. that I last saw h im alive on February 10 1920. and that death occurred on the date stated above, at 11 m P. M.
The CAUSE OF DEATH* was as follows:

Haemoptysis

(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Acute Lobar Pneumonia
(Duration) yrs. mos. 20 ds.

(Signed) George D. Landall M. D.
2-11 1920. (Address) Burke - Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 14 days. In the State yrs. mos. days
Where was disease contracted if not at place of death? Bunbury Ranch - Burke, Ida.
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Ida — DATE OF BURIAL: 2/13 1920

20. UNDERTAKER: Homer B Evans — ADDRESS: Burke

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 29339
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl. Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Warren Wesley Burke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 1 (Day) 1918 (Year)

7. AGE: 1 Yrs. 8 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: V
(b) General nature of industry, business or establishment in which employed (or employer): V

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Burke

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Lulu Castile

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Frank Burke
(Address) .....

15. Filed 2-19 1920 J. N. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1920, to Feb 13 1920, that I last saw h. in alive on Feb 12 1920, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Flu

..... (Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) Interstinal Type of Flu (Duration) ..... yrs. ..... mos. 9 ds.

(Signed) A. E. Buchanan M. D.

2/19 1920 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery	2/19 1920
20. UNDERTAKER	**ADDRESS**
J. E. Schmidt	Buhl.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 29360
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geneva Bowman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct ..... 1 ..... (Month) (Day) (Year)

7. AGE: 23 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dont Know

10. NAME OF FATHER: Mr Bowman

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L L Elliott
(Address)

15. Filed Feb. 18 1920 — J. V. Murphy, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb ..... 16 ..... 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1920, to Feb 16 1920, that I last saw h.. alive on Feb 16 1920, and that death occurred on the date stated above, at 1A M.

The CAUSE OF DEATH* was as follows:
Pneumonia

..... (Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Influenza
..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) H W Goodshell M. D.
Feb 18 1920 (Address) Burke, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF [illegible] OR REMOVAL: St. Louis — DATE OF [illegible]: Removed Feb 18 1920

20. UNDERTAKER: Homer B Evans — ADDRESS: Burke

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 39
Primary Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29361
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burl
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Mary Larsen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fmale
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1896 (Year)

7. AGE: 23 Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moroni Utah

10. NAME OF FATHER: C. B. Christiansen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Louisa L. Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Moroni, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Foster J. Larsen
(Address):

15. Filed Feb 25 1920
J. H. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1920, to Feb 23 1920
that I last saw her alive on Feb 23 1920
and that death occurred on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows:
Influenza Vera (Epidemic form)
(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary) Lobar pneumonia
(Duration) — yrs. — mos. 4 ds.
(Signed) F. A. Irvine. M. D.
Feb 25 1920 (Address) Buhl Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moroni Utah
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Homer B Evans
ADDRESS: Buhl

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 37

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 2087
File No. 29362
Registered No. ____

1. PLACE OF DEATH
County of Twin Falls
City of Buhl, Idaho
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katherine Seville Barry.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write word.)

6. DATE OF BIRTH: February 25 1920 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 4 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Buhl Idaho.

10. NAME OF FATHER: Harry N. Barry.

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Harriet Stein

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. W. Barry
(Address) Buhl Idaho

15. Filed Feb. 29 1920
H. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/25 1920, to 3/29 1920, that I last saw h[illegible] alive on 3/29 1920, and that death occurred on the date stated above, at 6A M.

The CAUSE OF DEATH* was as follows:
Respiratory failure
due to pneumonia during
birth
(Duration) ____ Yrs. ____ mos. 4 ds.

Contributory (Secondary) ____
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. Lue Clarke M. D.
3/3 1920 (Address) Buhl Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: Feb. 29 1920.

20. UNDERTAKER: Neville & Trigg — ADDRESS: Buhl Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Valley
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15
Primary Registration District No. .....
(No. ....., ... St.)

File No. 29363
Registered No. 39
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Not Given

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: Not Given (Month) 1 (Day) ..... (Year)

7. AGE: ..... yrs. 1 mos. 14 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.?*

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Ora Wilmoth

11. BIRTHPLACE OF FATHER (State or Country): Wn.

12. MAIDEN NAME OF MOTHER: Lena Evans

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G E Troggle
(Address) .....

15.
Filed 3-10 1920 Ruth Eagen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-4 1920 to 2-4 1920
that I last saw h in alive on 2-4 1920
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G E Troggle M. D.

19 ..... (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Vanwyck — DATE OF BURIAL: 2-6 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25564

Registered No. 58

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Valley
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME Claud M Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: not given (Month) 1 (Day) ..... (Year)

7. AGE: 35 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Moggle
(Address) .....

15.
Filed 3-10- 1920 Ruth Eagen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
2 (Month) 10. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-5-1920 to 2-10 1920 that I last saw h in alive on 2-8 1920 and that death occurred on the date stated above, at 10 AM.

The CAUSE OF DEATH* was as follows:
Heart Failure
(Dakage)

(Duration) 10 yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 5- ds.

(Signed) C E Moggle M. D.

19 ..... (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: alpha Ida
DATE OF BURIAL: 2-13 1920

20. UNDERTAKER
ADDRESS

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. _____
Primary Registration District No. 15
(No. _____, _____ St.)

File No. 29365
Registered No. _____

1. PLACE OF DEATH.
County of Valley
City of Donnelly
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Nickelsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August (Month) 17 (Day) 1860 (Year)

7. AGE: 59 Yrs. 10 Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ____
(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: John Rentakanga

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Mary — Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) ____
(Address) Paul Nickelsen Son

15. Filed 3-10 1920. Ruth Eagen Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [redacted] 191[redacted] to Jan 11 1920, that I last saw h[redacted] alive on Oct 20 1919, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Dropsy
(Duration) 5 Yrs. ____ mos. ____ ds.
Contributory (Secondary) Gallstones
(Duration ____ yrs. ____ mos ____ ds.

(Signed) G. E. Truggle M. D.
19____ (Address) ____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Finn Cemetery — DATE OF BURIAL: 1/15 1920.

20. UNDERTAKER — ADDRESS

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29366
Registered No. 56

1. PLACE OF DEATH.
County of Valley
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME Geo M Hellman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1893 (Year)

7. AGE: 27 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kas

10. NAME OF FATHER: Jno Hellman

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G E Boggle
(Address) Cascade Ida

15.
Filed 3-10- 1920 Ruth Eagen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 27 1920 to Feb 1 1920
that I last saw h[e] w alive on Feb 1 1920
and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary): Influenza
(Duration) ..... yrs. ..... mos. 20 ds.

(Signed) G E Boggle M. D.
1920 (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morgan Cem Cascade — DATE OF BURIAL: 2-6 1920

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

Conant

CERTIFICATE OF DEATH.

Registration District No. 86

Primary Registration District No. 1010

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29367

Registered No. ____

1. PLACE OF DEATH.

County of Washington

City of Weiser

(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ervin Dow Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 28 (Day) 1906 (Year)

7. AGE: 13 Yrs. 4 Mos. 3 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm. D. Hill

11. BIRTHPLACE OF FATHER (State or Country): Miss

12. MAIDEN NAME OF MOTHER: Alta Anderson

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. D. Hill

(Address) Council Ida.

15. Filed Jan 1st 1920

M. R. Hallmark
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

____ (Month) ____ (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29th 1919, to Jan 1920, that I last saw him alive on Jan 1st 1920, and that death occured on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:

Appendicitis purulent

complicated

(Duration) ____ Yrs. ____ mos. 5 ds.

Contributory (Secondary) 0

(Duration ____ yrs. 2 mos. ____ ds.

(Signed) C. C. Conant M. D.

1/1 1920 (Address) Weiser Idah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Council Idaho

DATE OF BURIAL: 1/2 1920

20. UNDERTAKER: Northam & McCann

ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 86
Primary Registration District No. 2112.
(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29568
Registered No. 2

1. PLACE OF DEATH.
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orson R. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov 1 1854 (Month) (Day) (Year)

7. AGE: 66 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jas Smith
(Address) Sucoy [illegible] Wash

15. Filed Jan 1st 1920 W. R. Hamilton Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 1. (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1919, to Dec 31 1919, that I last saw h[illegible] alive on Dec 31 1919, and that death occured on the date stated above, at 12 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of
Superior maxilla

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Jan 2 1920 (Address) Weiser

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Farview Cemetery Or — DATE OF BURIAL: 1/2 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-16-13

Watchman

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010.
(No. .... St.)

File No. 29369
Registered No. 3

1. PLACE OF DEATH.
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maud M Perkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Dec (Month) 26 (Day) 1883 (Year)

7. AGE: 36 Yrs. — Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: W R Sandifer

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Becky Ray

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C C Perkins
(Address) Weiser Ida

15. Filed Jan 9th 1920 W R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1920, to Jan 8 1920, that I last saw h[illegible] alive on Jan 8 1920, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
peritonitis following rupture of abdominal abscess

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G M Walkenhorst M. D.
1/9 1920 (Address) Weiser Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetry — DATE OF BURIAL: 1-9 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - VOSS CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 29370
Registered No. 4

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Cross Stephens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Nov. (Month) 19 (Day) 1854 (Year)
7. AGE: 65 Yrs. 1 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) R R Man
9. BIRTHPLACE (State or Country) Ohio
10. NAME OF FATHER E M Stephens
11. BIRTHPLACE OF FATHER (State or Country) Ohio
12. MAIDEN NAME OF MOTHER Mary Anna Goss
13. BIRTHPLACE OF MOTHER (State or Country) Penn'i
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary J Stephens
(Address) .....
15. Filed Jan 10 1920 W R Hunsaker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 10 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Dropped dead in a store in Weiser, Idaho.

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chester L. Taylor M. D.
1/10 1920 (Address) Weiser, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 1-12-1920
20. UNDERTAKER: Northam & McCain — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 29371
Registered No. 5

1. PLACE OF DEATH.
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Moses Elisha McCormick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. March (Month) 19 (Day) 1857 (Year)
7. AGE: 60 Yrs. 9 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Arkansas
10. NAME OF FATHER W F McCormick
11. BIRTHPLACE OF FATHER (State or Country) Alabama
12. MAIDEN NAME OF MOTHER Paralee Hopper
13. BIRTHPLACE OF MOTHER (State or Country) Tenn.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs M E McCormick
(Address) Weiser Idaho
15. Filed June 12 1920 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 12 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1, 1919, to Jan 12 1920, that I last saw h alive on Jan 12 1920 and that death occured on the date stated above, at P M.
The CAUSE OF DEATH* was as follows:
arteriosclerosis
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) General atheromatosis
Condition (Duration ..... yrs. ..... mos. ..... ds.
(Signed) W A Marshall M. D.
Jan 14 20 (Address) Weiser

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fullerton Cemetery — DATE OF BURIAL: 1-15 1920
20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Wallace

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 20372
Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phyllis Marion Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	Wht	single

6. DATE OF BIRTH.
Nov. (Month) 21 (Day) 1910 (Year)

7. AGE
9 Yrs. 2 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER C. J. Brown

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Fannie Morgan

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. J. Brown
(Address) Weiser, Idaho

15.
Filed 1/26 1920 W. R. Hamilton
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Jan 25 1920,
that I last saw her alive on Jan 25 1920
and that death occured on the date stated above, at 1 15 P.M.

The CAUSE OF DEATH* was as follows:
Mitral insufficiency

(Duration) 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Hamilton M. D.
1/26 1920 (Address) Weiser Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillcrest Cemetery	1/27 1920
20. UNDERTAKER Northam & McCann	ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

Washington 4-a m 28

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 29373
Registered No. 7

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Norman Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March (Month) 17 (Day) 1839 (Year)

7. AGE: 80 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: James Harris

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Malindy Mallory

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Della Dickey
(Address) Weiser Ida

15. Filed 1/30 1920 W R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:
I did not see him for several months. Cause of death was Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Waterhouse M. D.
1/30 1920 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Galloway Cemetery — DATE OF BURIAL: 1-30 1920

20. UNDERTAKER: Northam McCaw — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BNRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 29374
Registered No. 8

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Thorson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 13 (Day) 1883 (Year)

7. AGE: 36 Yrs. 9 Mos. 24 ds.
IF LESS than 1 day how many .....hrs. or .....min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Jas. Jones

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: — —

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred Thorson
(Address) .....

15. Filed Feb 12th 1920 — J. P. Hamilton — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2nd 1920, to Feb 7 1920, that I last saw her alive on Feb 7 1920 and that death occured on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Flu

(Duration) 0 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration ..... yrs. ..... mos. 3 ds.

(Signed) W. A. Marshall M. D.

Feb 12 1920 (Address) Weiser

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 2-13 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 29515
Registered No. 9

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Arnold Suetzler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Dec (Month) 23 (Day) 1849 (Year)

7. AGE: 80 Yrs. 2 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Henry H Arnold

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Martha Kiser

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hattie Shrarai
(Address) Weiser Idaho

15. Filed March 10 1920 W. R. Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920 to Mch 9 1920 that I last saw her alive on Mch 4 1920, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH*, was as follows:
Paralysis

(Duration) ..... Yrs. ..... mos. 18 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. M. Malcolm M. D.
Mch 10 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery
DATE OF BURIAL: 3/11 1920

20. UNDERTAKER: Northam & McCann
ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington — Registration District No. 86 — File No. 29376

City of Weiser — Primary Registration District No. 1010 — Registered No. 10

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Douglas E. Weston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male | 4. COLOR OR RACE: White | 5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 20 (Day) 1887 (Year)

7. AGE: 33 Yrs. — Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid
(b) General nature of industry, business or establishment in which employed (or employer): All Life

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas Weston

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Minnie Poyer

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles W. Weston
(Address) Weiser Ida

15. Filed 3/12 1920 — W. R. Hamilton — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 10 1920, to ..... 19..... that I last saw h[illegible] alive on Mch 10 1920, and that death occurred on the date stated above, at 19 M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Duration

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. M. Mahlkeim M. D.
Mch 11 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL: 3/12 1920

20. UNDERTAKER: Woodhouse & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29377

Registered No. 11

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis & Clark — Registration District No. 86

City of Helena — Primary Registration District No. 1010

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME R. W. Crosby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Man

4. COLOR OR RACE: White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 81 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Brockett

(Address) G. F. D. No 1

15. Filed Feb 12th 1920 — W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility
Died before medical assistance arrived

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. C. Northam Coroner M.D.

2/12 1920 (Address) Weiser. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 2/15 1920

20. UNDERTAKER: Northam & McCown — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNS - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
(No. ..... St.)

File No. 29378
Registered No. 12

1. PLACE OF DEATH.
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Rowland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W	

6. DATE OF BIRTH. Feb. (Month) 14 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wilbert Rowland

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Alice Abbott

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wilbert Rowland
(Address) Weiser Idaho

15. Filed Feb 15th 1920 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 15th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14th 1920, to Feb 14th 1920, that I last saw him alive on Feb 14th 1920, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Inanition

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

2/15 1920 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hellers Cemetery	2/15 1920

20. UNDERTAKER	ADDRESS
Northam & McCann	Weiser Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 212
File No. 29379
Registered No. 13

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH.
Oct (Month) — (Day) 1870 (Year)

7. AGE
49 Yrs. 4 Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Truls Lind

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Karna Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Otto Cranwall
(Address) Weiser Ida

15.
Filed Feb 18th 1920 F. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Febry. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 8 1920, to Febry 15 1920, that I last saw her alive on Febry 15 1920, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(Duration) 0 Yrs. 0 mos. 5 ds.
Contributory (Secondary) Influenza
(Duration 0 yrs. 0 mos. 10 ds.
(Signed) A C Cameron M. D.
2/18 1920 (Address) Weiser Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill. DATE OF BURIAL 191

20. UNDERTAKER: Northcraft & McCann ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 29380
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Jasper Carey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Aug. (Month) 31 (Day) 1877 (Year)

7. AGE 42 Yrs. 4 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Melvin Carey

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Martha E Brown

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) M. M. Hawks

(Address) Midvale

15. Filed 2/18 1920 W. R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febry. (Month) 16th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 14 1920, to Febry 16th 1920, that I last saw him alive on Febry 16 1920, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(Duration) 0 Yrs. 0 mos. 3 ds.

Contributory (Secondary) Influenza

(Duration 0 yrs. 0 mos. 7 ds.

(Signed) C C Garrett M. D.

2/18 1920 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Hillcrest Cemetery — **DATE OF BURIAL** 2-18 1920

20. UNDERTAKER Northam McCann — **ADDRESS** Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. .... St.)

File No. 29381
Registered No. 15

1. PLACE OF DEATH.
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lois Carey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH.
Oct. (Month) 13 (Day) 1904 (Year)

7. AGE
15 Yrs. 5 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School Girl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Washington

10. NAME OF FATHER Marion Jasper Carey

11. BIRTHPLACE OF FATHER
(State or Country) Washington

12. MAIDEN NAME OF MOTHER Lena Hawks

13. BIRTHPLACE OF MOTHER
(State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. W. Hawks.
(Address) Weiser Idaho

15.
Filed 2/18 1920 W. B. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Febry. (Month) 17th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 15th 1920, to Febry 17 1920, that I last saw her alive on Febry 17 1920 and that death occured on the date stated above, at 12 15 a. M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
.....
(Duration) 0 Yrs. 0 mos. 3 ds.
Contributory (Secondary) Scarlet Fever
(Duration — yrs. — mos. 7 ds.

(Signed) C. C. Garrett M. D.
2/18 1920 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fellcrest Cemetery	2-18 1920
20. UNDERTAKER	ADDRESS
Northam McCain	Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

Coroner

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 2112

(No. ....., ... St.)

File No. 29282

Registered No. 196

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Neal Gulbransen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. Feb. (Month) ..... (Day) 1857 (Year)

7. AGE 63 Yrs. — Mos. — ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housework

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Andrew Jensen

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Frank Gulbransen

(Address) R.F.D. Weiser, Idaho

15. Filed 2/18 1920

W R Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febry (Month) 17th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 10th 1920, to Febry 17 1920, that I last saw her alive on Febry 17th 1920, and that death occured on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

.....(Duration) 6 Yrs. 0 mos. 6 ds.

Contributory (Secondary) Influenza

.....(Duration — yrs. — mos. 10 ds.

(Signed) C C Conant M. D.

2/18 1920 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Hyrum Utah | DATE OF BURIAL .....191..

20. UNDERTAKER Northam McCaud | ADDRESS Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 816
Primary Registration District No. 2012
(No. ....., ... St.)

File No. 29383
Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lawrence M. Beauguard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 11 (Day) 1910 (Year)

7. AGE: 10 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): No. Dak

10. NAME OF FATHER: W. C. Beauguard

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Edith Weeks

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. C. Beauguard
(Address) Weiser Ida

15. Filed Feb 22nd 1920 M. R. Schmidlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Febry. 21st (Month), (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 1 1920, to Febry 21 1920, that I last saw h— alive on Febry 21 1920, and that death occured on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Acute nephritis (anuria complete)

1 (Duration) 4 Yrs. mos. 3 ds.
Contributory (Secondary) Scarlet Fever
(Duration yrs. mos. 14 ds.

(Signed) C. A. Smart M. D.
2/21 1920 (Address) Weiser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Ida — DATE OF BURIAL: 2/22 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ....., ... St.)
Registration District No. 86
Primary Registration District No. 1010
File No. .....
Registered No. 29284

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah a Perkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. April (Month) 19 (Day) 1841 (Year)

7. AGE: 78 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ind.

10. NAME OF FATHER Jas Collins

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Nancy Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. C. Perkins
(Address) Weiser Ida

15. Filed Feb 23rd 1920 W. R. Hamilton Local Registrar

SYMS - YORK CO., PYRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920, to ..... 191..., that I last saw h.. alive on Feb 20 1920, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Senility
Don't Know
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. M. Hutchinson M. D.
Feb 23 1920 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fullerest Cemetery | DATE OF BURIAL: 2-24 1920

20. UNDERTAKER: Northam McCann | ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 20385
Registered No. 29385

1. PLACE OF DEATH.
County of Washington
City of Weiser
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W. Day

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 27 (Day) 1883 (Year)

7. AGE: 37 Yrs. ..... Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Leyander Day

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Ara Smith

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Leo W Triplett
(Address) Weiser Idaho

15. Filed Feb 26 1920 F. R. Hewlett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 25 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/18 1920, to 2/25 1920, that I last saw h[illegible] alive on 2/25 1920, and that death occured on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
following La Grippe.
(Duration) ..... Yrs. ..... mos. 4. ds.
Contributory (Secondary) Oedema of Lungs
(Duration ..... yrs. 1 mos. 2 ds.
(Signed) Ernest O'Feeney M. D.
2/25 1920 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetry — DATE OF BURIAL: 2-26 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29386

Registered No. 20

1. PLACE OF DEATH.

County of Washington

City of Weiser

(No. ..... St.)

Registration District No. 84

Primary Registration District No. 2112

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J Ledington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 11 1

(Month) (Day) (Year)

7. AGE: 53 Yrs. 8 Mos. 2 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Elezia Ledenglan

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mary Lovett

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Marion Ledington

(Address) Weiser Idaho

15. Filed March 3rd 1920 W R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March (Month) 3rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20th 1920, to March 3rd 1920, that I last saw him alive on March 1st 1920, and that death occured on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

3/3 1924 (Address) Weiser Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Galloway Cemetery — DATE OF BURIAL: 3/4 1920

20. UNDERTAKER: Northcraft & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 86
County of Washington Primary Registration District No. 1010
City of Weiser (No. ....., ... St.)
File No. 29387
Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Francis Sommercamp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Feb. (Month) 16th (Day) 1860 (Year)

7. AGE 60 Yrs. no Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Merchant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Yreka, Humbolt Co. Calif.

10. NAME OF FATHER William Franz, Sommercamp

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Mary Elizabeth Slack.

13. BIRTHPLACE OF MOTHER (State or Country) Zanesville Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. G. Cordelle
(Address) Weiser Idaho

15. Filed March 4 1920 W. R. Ewell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 23 1920, to March 3 1920 that I last saw him alive on March 3 1920 and that death occured on the date stated above, at 2.40 pm

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C B Shirley M. D.
3/3 1920 (Address) Weiser, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Fullcrest Cemetry | DATE OF BURIAL 3-5 1920

20. UNDERTAKER Markham & McCann | ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Washington
City of Weiser

Registration District No. 56
Primary Registration District No. 2112
(No. ..... St.)

File No. 29388
Registered No. 92

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer Cole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 9 (Day) 1885 (Year)

7. AGE: 24 Yrs. 5 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph Cole

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Celia Woodland

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. T. Cole
(Address) Pratt Rd. No 5

15. Filed 3/6 1920 Date. M. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 4th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Killed by R.R. Train
While crossing track

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. C. Northam Coroner M. D.
3/6 1920 (Address) Weiser, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Syringa Idaho
DATE OF BURIAL ..... 191...

20. UNDERTAKER: Northam McCann
ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2112
File No. 29389
Registered No. 93

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Lucile Snyder
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 6 (Day) 1916 (Year)

7. AGE: 3 Yrs. 6 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Herbert R Snyder

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Bertha A Mellow

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Minnie Snyder
(Address) Weiser Ida

15. Filed March 6th 1920 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/2 1920, to 3-6 1920.
that I last saw her alive on 3-6 1920
and that death occurred on the date stated above, at 11.30 A.M.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia
following Influenza
(Duration) Yrs. ..... mos. 5 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) Ernest O. Finney M. D.
3/6 1920 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery | DATE OF BURIAL: 3-7 1920

20. UNDERTAKER: Northam & McCann | ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise.

Registration District No. 8

Primary Registration District No. 2 2 7 4

(No. Soldiers Home Hospital St.)

File No. 29390

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William N. N. Morris.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Married (or Widowed)

6. DATE OF BIRTH: Oct 12 1840 (Month) (Day) (Year)

7. AGE: 79 Yrs. 5 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Hiram Morris.

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Sarah Gorton

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. R. Morris
(Address) 1503 N. 5th St. Boise

15. Filed Mar 25 1920 L. P. Summers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/1 1920 to 3/23 1920 that I last saw h.. alive on 3/22 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Tourtellotte M. D.

3/24 1920 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: 3/25 1920

20. UNDERTAKER: Summers & Keb. ADDRESS: Boise, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

29391

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3259

Registration District No. 84
Primary Registration District No. 2161
(No. Pleasant Hosp'l St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock
City of Pocatello

2. FULL NAME Ray D. Keith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. Nov 2 1887
(Month) (Day) (Year)

7. AGE: 32 Yrs. 3 Mos. 23 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): So Dakota

10. NAME OF FATHER: E. C. Keith

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Alice Perry

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Robert M. Keith
(Address): Payette Idaho

15.
Filed Mar 14 1920
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 12 1920 to Mch 13 1920
that I last saw h[illegible] alive on Mch 13 1920
and that death occurred on the date stated above, at 3:50 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia, Lobar

(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)

(Duration) .... Yrs. .... mos. .... ds.

(Signed) C. K. Spraguer M. D.
Mch 13 1920 (Address) Rainbeau

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 10 yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death?
Former or usual residence Payette Idaho

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL 1920

20. UNDERTAKER: W. L. McHan
ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 2993
Registered No. 100

1. PLACE OF DEATH
County of Ada.
City of Boise.
(No. St. Lukes Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Pope.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: July — 7 — 1878
(Month) (Day) (Year)

7. AGE: 41. Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: William Woodall

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Sarah J. Williams

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise, Idaho.

15. Filed Mar 1 1920 L. A. Jensen Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb, 28, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 28 19.., to Feb. 28 1920
that I last saw her alive on Feb. 28 1920
and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:

Post Partum Hemorrhage

(Duration) ..... Yrs. ..... mos. ½ ds.

Contributory (Secondary) Lac of Nourishment Tense

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Allen Cassaway M. D.
2/28 1920. (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery. DATE OF BURIAL: Mch 1 1920

20. UNDERTAKER: W. McBratney ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29393
Registered No. 15-7

1. **PLACE OF DEATH**

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 408 Logan St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Thomas Arthur Mott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	White	Married

6. **DATE OF BIRTH** Dec (Month) 11 (Day) 1867 (Year)

7. **AGE** 52 Yrs. 4 Mos. 9 ds.

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Lumber dealer

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Wisconsin

10. **NAME OF FATHER** Unknown

11. **BIRTHPLACE OF FATHER** (State or Country) Unknown

12. **MAIDEN NAME OF MOTHER** Unknown

13. **BIRTHPLACE OF MOTHER** (State or Country) Unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Frank Mott

(Address) 408 Logan

15. Filed April 22 1920 L. P. Thomas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** April (Month) 20 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Oct. 27 1920, to Apr. 20, 1920, that I last saw h[illegible] alive on Apr. 20, 1920, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

9 (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. H. Dalemon M. D.

4/21 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Morris Hill Cemetery | **DATE OF BURIAL** April 22 1920

20. **UNDERTAKER** Summers & Krebs | **ADDRESS** Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29394

Registered No. 15

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Idan Ha Hotel St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James H Burns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White.	Married

6. DATE OF BIRTH: Oct (Month) 23 (Day) 1874 (Year)

7. AGE: 45 Yrs. 2 Mos. 23 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: John L Burns

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Jane Hand

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno. R. Burns
(Address) Rocatello Ida

15. Filed April 22 1920 L. C. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ Dead
April 19 19..., to ...19...,
that I last saw h... alive on ...19...,
and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:
Apoplexy found dead in room at Hotel, was missed April 16 and was not found dead until April 19, Dead one week
(Duration) 19 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Clyde E Summers Coroner
4/22 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Idaho
DATE OF BURIAL: Apr 23 1920

20. UNDERTAKER: Summers & Kreb
ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

STATE OF IDAHO)
) ss
County of Canyon)

Lizzie L. Burns, being first duly sworn, deposes and says:

That she is a citizen of the State of Idaho and a resident of the County of Canyon in said State: That she is the surviving wife of LOU H. BURNS, who parted this life between the 16th and the 19th days of April, 1920, in a room at the Idanha Hotel in the City of Boise, County of Ada, State of Idaho;

That, through some inadvertance and mistake, a brother of the said deceased, to-wit: John R. Burns, in giving the information necessary for to make up the "Certificate of Death", gave the first name of said decedent as Lewis, when in truth and in fact decedent's true first name was Lou;

That the said decedent received his final naturalization papers at a regular term of the District Court of the County of Canyon, State of Idaho, held at Caldwell on the 6th day of November, 1912, and that his first name appears in the said naturalization paper as Lou, which was his true name.

Lizzie L. Burns

Subscribed and sworn to before me, this 1st day of June, 1920.

Notary Public residing at Caldwell, Idaho.

FORM V. S. No. 5-25 M. 1-19.

Taylor

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau 2[redacted]tics

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. 2017 No 13 St.)
Registration District No. 2
Primary Registration District No. 1004
File No.
Registered No. 129

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence May Shaul

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Mar 25 1920.
(Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Earnest Shaul.

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Iona Culver.

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earnest Shaul.
(Address) 2017 No 13 St Boise Ida

15. Filed Mar. 27 1920 L. P. Thomas
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 27th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 25th 1920, to Mch 27th 1920, that I last saw h[illegible] alive on Mch 26th 1920, and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH*, was as follows:
Suffocation - either from accumulation of mucus in throat or turning on face -
(Duration) 1 yrs. hours ds.
Contributory (Secondary) Baby had nursed normally after midnight
(Duration) yrs. mos. ds.

(Signed) J. M. Taylor M. D.
Mch 27th 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery
DATE OF BURIAL: Mar 28 1920
20. UNDERTAKER: Summers & Kebo.
ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29396

Registered No. 128

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 Washington St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abel Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. September 10 (Month) (Day) 1870 (Year)

7. AGE 49 Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Beyt Caldwell

(Address) Canon Kapin Oregon

15. Filed 3-26- 1920 L. P. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 25 1920 to Mch 26 1920, that I last saw h[illegible] alive on Mch 26 1920 and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) Yrs. mos. 15 ds.

Contributory (Secondary) General peritonitis

(Duration) yrs. mos. 10 ds.

(Signed) W. H. Tallman M. D.

3/26 1920 (Address) Boise, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Canon Kapin Ore.

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 3/27 1920

20. UNDERTAKER: Schreiber & Redemsden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29397

Registered No. 130

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 223 So 16th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hilt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March (Month) 27 (Day) 1842 (Year)

7. AGE: 78 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Kentucky.

10. NAME OF FATHER: Jessie Hilt

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Rosanna Strickland

13. BIRTHPLACE OF MOTHER (State or Country): Pensylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. L. S. Garner

(Address) 223-S. 16th St.

15. Filed Mar 29 1920

L. P. Inman
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 27th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility

Heart Complication

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. V. Genoway M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 3/29/1920

20. UNDERTAKER: Schneider & Lidenpaden | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29398
Registered No. 171

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 1st St.)
Registration District No. 2
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes C. Friedman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 7 (Day) 1920 (Year)

7. AGE: 3 Yrs. 3 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vernal Utah

10. NAME OF FATHER: Albert V. Friedman

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Anna M. Manns

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert V. Friedman
(Address) Mt. Home, Idaho.

15. Mar 31 20
Filed Mar 31 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3/30 (Month) March 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/20 1920, to 3/30 1920, that I last saw her alive on 3/29 1920, and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Sepsis Empyema

(Duration) Yrs. mos. ds.
Contributory (Secondary) Bronchopneumonia

(Duration yrs. mos. ds.
(Signed) F. A. Palmerton M. D.
3/30 1920 (Address) Overland Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home | DATE OF BURIAL: 3/30 1920

20. UNDERTAKER: Schuster & Sidenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24653

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

9 FH 2

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29399

Registered No. 132

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 712 Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wong Duck Long

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. about (Month) 1831 (Day) (Year)

7. AGE about 88 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charley Wong

(Address) .....

15. Filed Mar 31 1920 L. Thomas Local Registrar

Collister

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 31st 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1920, to March 30 1920, that I last saw him alive on March 30 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm Collister M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery | DATE OF BURIAL: 4/1 1920

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: (Boise)

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29401
Registered No. 105

1. PLACE OF DEATH
County of Ada
City of Boise
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E. Cooper.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write one word.): Widow.

6. DATE OF BIRTH: Apr 9 1856 (Month) (Day) (Year)

7. AGE: 63 Yrs. 10 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Samuel T. Coate.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Harriet Anthony.

13. BIRTHPLACE OF MOTHER (State or Country): Massachusetts

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Cooper
(Address) Ogden Iowa

15. Filed March 16 1920 L. Eggman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 1 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ March 1 1920, ~~to ..... 19....~~
~~that I last saw h..... alive on ..... 19....~~
and that death occurred on the date stated above, at 6:15 P. M.

The CAUSE OF DEATH* was as follows:
Fracture of Skull, Automobile accident

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner
3/3 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Iowa. DATE OF BURIAL: Mar. 9 1920

20. UNDERTAKER: Summers & Webb. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

Stewart

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29402
Registered No. 106

1. PLACE OF DEATH

County of Ada.
City of Boise.
(No. St Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys Marsters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word.)

6. DATE OF BIRTH: Oct 4 1901
(Month) (Day) (Year)

7. AGE: 12 Yrs. 5 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Les E. Marsters.

11. BIRTHPLACE OF FATHER (State or Country): Nebraska.

12. MAIDEN NAME OF MOTHER: Julia E. Huntley.

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L E Marsters
(Address) .....

15. Filed Mar 5 1920 L. O. Jones
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 3 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 20 1920 to Mch 3 1920 that I last saw h..... alive on Mch 3 1920, and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

..... (Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James L Clement M. D.
3/4 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian Cemetery	Mar 5 1920.
20. UNDERTAKER	ADDRESS
Summers & Cobb.	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29403
Registered No. 108

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 100 East Jefferson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bridgett H. Callahan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Jan (Month) 5 (Day) 1853 (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Michael Harrington

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Nora Regan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mollie Hill
(Address) Boise

15. Filed Mar. 10 1920 L. O. Blanchard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920, to Jan 8 1920, that I last saw her alive on Jan 8 1920 and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Lothrop M. D.

3/9 1920 (Address) Corbett Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 3/11 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 24852

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29404

Registered No. 109

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 Hate St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel L. Bartlett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April 9 1874 (Month) (Day) (Year)

7. AGE: 45 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: John Bascom

11. BIRTHPLACE OF FATHER (State or Country): Ame.

12. MAIDEN NAME OF MOTHER: Miss Conklin

13. BIRTHPLACE OF MOTHER (State or Country): Ame.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. Bartlett

(Address) Boise Ida

15. Filed March 10 1920 L. P. Gunn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920, to March 9 1920, that I last saw her alive on March 1920, and that death occured on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Influenza + Pneumonia

(Duration) Yrs. 1 mos. 9 ds.

Contributory (Secondary) Emphysema

(Duration yrs. mos. 14 ds.

(Signed) Dr Wm Hayes M. D.

3/9 1920 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos 15 days In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence 1216 Bonnie Ave., Boise Ida

19. PLACE OF BURIAL OR REMOVAL: Mackay Idaho — DATE OF BURIAL: 3/10 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Hayes

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29405
Registered No. 110

1. PLACE OF DEATH
County of Ada.
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. North Harrison Blvd., St.)

2. FULL NAME Lois McGee Pavey.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May, 26 — 1910
(Month) (Day) (Year)

7. AGE: 9 Yrs. 9 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burns — Ore.

10. NAME OF FATHER: Marvin McGee

11. BIRTHPLACE OF FATHER (State or Country): Oregon.

12. MAIDEN NAME OF MOTHER: Pearl Brown

13. BIRTHPLACE OF MOTHER (State or Country): Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Pavey. mcb
(Address) Boise Idaho.

15. Filed Mar 10 1920 L. P. Summers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch — 9 — 1920.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1 1920, to Mch 8 1920, that I last saw h.r. alive on Mch 8 1920, and that death occurred on the date stated above, at 11 a. M.
The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... Yrs. ..... mos. 20 ds.
Contributory (Secondary) ~~Cardiac~~ Mitral insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jos R. Summers M. D.
3/10 1920. (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. ~~LENGTH~~ OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burns — Oregon | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: W. McBratney | ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 25406
Registered No. 111

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 410 W. State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irene Naftzger Walters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: June (Month) 2 (Day) 1844 (Year)

7. AGE: 75 Yrs. 7 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Young

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Naftzger.
(Address) Boise Ida

15. Filed March 12 1920 L. O. Summers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15th 1920 to March 9th 1920 that I last saw h.e alive on March 8th 1920 and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Dropsy - Dilatation of Heart

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bad Lesions
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Stubbock M. D.
March 12 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: March 12 1920
20. UNDERTAKER: Summers & Reed ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 110 E. Bannock St.)

File No. 29407

Registered No. 112

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel Comley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH Sept (Month) 3 (Day) 1821 (Year)

7. AGE 98 Yrs. 4 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Retired Miner

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E. Summers

(Address) Boise Ida

15. Filed Mar. 16 1920 L. O. Green Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 19.., to Mch 13 1920, that I last saw him alive on Mch 13 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. D. Smith M. D.

3/15 1920 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery	Mar 16 20
20. UNDERTAKER	ADDRESS
Summers & Gray	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29408

Registered No. 13

Registration District No. 2

Primary Registration District No. 2004

1. PLACE OF DEATH

County of Ada.

City of Boise (No. 317 Grove St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H. A. Coal.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH June (Month) 14 (Day) 1851 (Year)

7. AGE 68 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Locomotive

(b) General nature of industry, business or establishment in which employed (or employer): Engineer

9. BIRTHPLACE (State or Country) Ohio.

10. NAME OF FATHER Hugh Coal

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McBratney

(Address) Boise. Idaho.

15. Filed Mar 16 1920 L. C. Jones Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1 1920, to Mch 12 1920 that I last saw h[illegible] alive on Mch 12 1920, and that death occurred on the date stated above, at 9:45 M.

The CAUSE OF DEATH* was as follows:

Bright's disease

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) acute dilation of heart. Mitral insufficiency

..... (Duration) ..... yrs. 5 mos. ..... ds.

(Signed) H. M. Holverson M. D.

3/15 1920 (Address) Boise. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	3/16 1920
20. UNDERTAKER W. McBratney	ADDRESS Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29409

Registered No. 114

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1610 N 11 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Erina Thurber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Oct 21 1874 (Month) (Day) (Year)

7. AGE: 45 Yrs. 4 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Coal dealer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Albert N. Thurber

11. BIRTHPLACE OF FATHER (State or Country): Rhode Island

12. MAIDEN NAME OF MOTHER: Agnes Brockbank

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. A. Washington
(Address) 431 S 11th St Boise Ida

15. Filed Mar 18 1920 L. P. Pfuman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 14 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10th 1920 to Mar 13th 1920 that I last saw ~~him~~ alive on Mar 13th 1920 and that death occurred on the date stated above, at 6a M.

The CAUSE OF DEATH* was as follows:
Myocarditis & other complications (Bowel Stoppage) Following Flu, Pneumonia
(Duration) Yrs. 1 mos. 14 ds.
Contributory (Secondary) Asthma
(Duration) 6 yrs. mos. ds.

(Signed) Geo. N. Vaudy M. D.
Mar 17 1920 (Address) 916 State St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 6 mos. ..... days. In the State 14 yrs. 9 mos. 14 days
Where was disease contracted if not at place of death? 1101 Front St. Boise
Former or usual residence Eight Mile

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 17 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

25410

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1124 W. Bannock St.)

Registration District No. 2

Primary Registration District No. 1004

File No.

Registered No. 115

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Burt W. Roosbrook

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): divorced

6. DATE OF BIRTH: Dec (Month) 15 (Day) 1873 (Year)

7. AGE: 46 Yrs. 3 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E. Summers

(Address) Boise Ida

15. Filed Mar 18 1920 L. O. Peterman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 29 1920, to Mar 16 1920 that I last saw him alive on Mar 12 1920 and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Acute Myocarditis

(Duration) ..... yrs. ..... mos. 18 ds.

(Signed) T. N. Braxton M. D.

Mar 17 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 24 1920

20. UNDERTAKER: Summers & Hyde — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29411

Registered No. 116

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 301 South 3rd St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Elizabeth Sanders

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April 24th 1852 (Month) (Day) (Year) 1852

AGE: 68 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) House Wife

9. BIRTHPLACE (State or Country) Miss

10. NAME OF FATHER Isaac H. Buck

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER Biddie R. Steel

13. BIRTHPLACE OF MOTHER (State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Hattie Nicholas

(Address) Boise Idaho

15. Filed Mar 18 1920 L. P. Pfuman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 15 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1920, to Mar 15 1920, that I last saw h.r alive on Mar 14 1920, and that death occured on the date stated above, at 1:55 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis

.....(Duration) .....Yrs. 3 mos. .....ds.

Contributory (Secondary) Nephritis

.....(Duration .....yrs. 1 mos. .....ds.

(Signed) J. M. Stevens M. D.

Mar 16 1920 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/18 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2941 2

Registered No. 117

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 104

(No. St. Alphonsus Hospital, St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Kennedy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: April — 17 — 1837 (Month) (Day) (Year)

7. AGE: 82 Yrs. 10 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McBratney

(Address) Boise Idaho

15. Filed Mch 19 1920 L. P. Plummer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch. — 16 — 1920. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920, to March 16 1920 that I last saw h... alive on mch 16 1920; and that death occurred on the date stated above, at 1 30 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Jno Callen M. D.

3/17 1920 (Address) Boise, Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/17 1920

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29413
Registered No. 118

1. PLACE OF DEATH
County of Ada
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1004
(No. Ada Co. Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Campbell.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Married (the word.)

6. DATE OF BIRTH: Dec 23 (Month) (Day) 1847 (Year)

7. AGE: 72 Yrs. 2 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mining Engineer.
(b) General nature of industry, business or establishment in which employed (or employer): ?

9. BIRTHPLACE (State or Country): Scotland.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mark W Awkerman
(Address) Hailey - Idaho

15. Filed Mar 20 1920 L. P. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 14 1920 to Mch. 19 1920
that I last saw h.was alive on Mch. 19 1920
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Peritonitis from perforation of bowel
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Carcinoma of Colon.
(Duration) ..... yrs. 9 mos. ..... ds.
(Signed) J S Springer M. D.
Mar 20 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hailey Idaho	Mar 21 1920
20. UNDERTAKER	**ADDRESS**
Summers & Keeler	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29414
Registered No. 119

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriet Myers.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. about (Month) 1 (Day) 1891 (Year)

7. AGE: about 28 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dress Maker
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Peru, Ind.

10. NAME OF FATHER: John Myers

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ernestine Wells
(Address) Boise, Idaho

15. Filed Mar. 20 1920 L. O. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 19th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1920, to March 18th 1920, that I last saw her alive on March 18 1920, and that death occured on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:
Pneumonia following Bronchitis
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.
(Signed) Jos. R. Flanagan M. D.
3/20 1920 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) Statehouse Hospital.
At place of death ... yrs ... mos. 2 days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence Boise Jerome Idaho

19. PLACE OF BURIAL OR REMOVAL: Peru, Ind. DATE OF BURIAL: 3/22 1920

20. UNDERTAKER: Schreiber & Siebenfaden ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29415

Registered No. 120

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Long

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. .....(Month) .....(Day) 1 (Year)

7. AGE: 32 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: James D. Long

11. BIRTHPLACE OF FATHER (State or Country): Illegible

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. W. Cone

(Address) Boise Idaho

15. Filed Mar 21 1920 L. O. Sims Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 12 1920, to Mar 19 1920, that I last saw h[illegible] alive on Mar 19 1920, and that death occured on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) H. H. Gittings M. D.

3/21 1920 (Address) Overland Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Grangeville Ida

19. PLACE OF BURIAL OR REMOVAL: Grangeville Ida — DATE OF BURIAL: 3/22 1920

20. UNDERTAKER: Schreiber & Liedtke — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25, M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29417

Registered No. 122

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 Washington St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Joseph Gray.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 23 (Month) (Day) 18[illegible] (Year)

7. AGE: 50 Yrs. 11 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sheepman and Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah County, Utah

10. NAME OF FATHER: Joseph R. Gray.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Marshall

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. G. Gray.

(Address) 1014 No. 17th St. Boise Ida.

15. Filed Mar 23 1920 L. O. Sprague Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 19 1920 to Mar 21 1920 that I last saw h[illegible] alive on Mar 21 - 1920, and that death occured on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Dilatation of heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza.

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Sprague M. D.

Mar 22 1920 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT [illegible]s, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institut[illegible] Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 3/24 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29418

Registered No. 123

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

County of Ada

City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaretta W. Heath

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH. (Month) (Day) 1847 (Year)

7. AGE 73 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Wm. Wiseman

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mc Donnell

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Katherine F. McGrath

(Address) 1610 N. 12 St.

15. Mar 29 20

Filed Mar 29 1920 L. Thomas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1919 to Dec 19 1919, that I last saw h. alive on Dec 19 1919, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

followed by paralysis.

(Duration) Yrs. 4 mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs ..... mos. ..... ds.

(Signed) Jno. R. Nuzum M. D.

19 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	3/25 1920

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMB - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29419
Registered No. 124

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1107 Grove St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary J. Le Flavours

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 11 (Day) 1918 (Year)

7. AGE: 4 Yrs. 4 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Bicknell

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Olive Barker

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. LeFlavours

(Address) 1107 Grove St.

15. Filed March 24 19 L. D. Gunn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ March 23 1920 to 19.....

that I last saw her ~~alive~~ dead on Mar 23 1920

and that death occurred on the date stated above, at 5 30 P. M.

The CAUSE OF DEATH* was as follows:

Accidently killed by automobile.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner M. D.

3/24 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Mar. 25 1920

20. UNDERTAKER: Summers & Reb — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

30

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29420

Registered No. 99

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1414 Hark 11 St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Spencer Records

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 9 (Day) 1867 (Year)

7. AGE: 52 Yrs. 4 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)... Capital Bldg

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John S. Records

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Maggie Johnson

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John S. Records
(Address) Boise

15. Filed Mar. 1 1920
L. J. Simon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1920, to Feb 1920, that I last saw him alive on Feb 26 1920, and that death occured on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chris Bodle Maguire M. D.

Feb 27 1920 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 2/29 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & ENGS. 24858

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29421
Registered No. 101

1. PLACE OF DEATH
County of Ada.
City of Boise.
(No. St. Alphonsus Hospital, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie May Babcock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April (Month) 1 (Day) 1873 (Year)

7. AGE: 46 Yrs. 4 Mos. 10 ds. 28
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Henry C. Smith

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary E. Hummel

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise. Idaho.

15. Filed Mar 1 1920 L. O. Inman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) — 28 (Day) — 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25th 1920, to Feb. 28th 1920, that I last saw h.er alive on Feb. 28 1920, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Acute dilatation Stomach, Caused by Surgical anaesthesia Shock,
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) L. O. McCalla M. D.
3/1 1920. (Address) Boise. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ontario, Ore. DATE OF BURIAL: 3/2 1920.

20. UNDERTAKER: W. McBratney ADDRESS: Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29422

Registered No. 103

1. PLACE OF DEATH

County of Ada

City of Boise

(No. ..... St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William James Thompsan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Feb. 26 1845
(Month) (Day) (Year)

7. AGE

74 Yrs. — Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lemms Ferry Idaho

10. NAME OF FATHER W J Thompsan

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Cathran Corcoran

13. BIRTHPLACE OF MOTHER (State or Country) Placer Ville Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed March 2, 1920 L. O. Green
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 1st 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/1 1920 to 3/1 1920

that I last saw him alive on 2/1 1920

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry G ..... M. D.

3/2 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	 1920
20. UNDERTAKER	**ADDRESS**
Wm McBratney	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29423

Registered No. 70

1. PLACE OF DEATH (13)

County of Ada

City of near Boise.

(No. Country Club, St.)

Registration District No. 8

Primary Registration District No. 2054

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles N. Sumption

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Sept 17. (Month) (Day) 1 (Year)

7. AGE: 44 Yrs. Mos. 5 ds. 11

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Automobile Salesman.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Charles A. Sumption.

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. N. Sumption

(Address)

15. Filed Mar 1 1920 L. P. McCalla Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 29 1920, to 19..., that I last saw h.[illegible] alive on Feb 29 1920, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris. Probably embolism of coronary artery. (Death only took 5 minutes after Onset.) (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. P. McCalla M. D.

3/1 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Mar 2 1920

20. UNDERTAKER: Summers & Cobb. ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 8
Primary Registration District No. 2004
File No. 29424
Registered No. 27

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of
(No. near Boyard Station St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Mc Donald
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR, DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. April (Month) 16 (Day) 1840 (Year)
7. AGE: 79 Yrs. 10 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Tenn.
10. NAME OF FATHER Mr. Scott
11. BIRTHPLACE OF FATHER Tenn (State or Country)
12. MAIDEN NAME OF MOTHER Betsy Scott.
13. BIRTHPLACE OF MOTHER Tenn. (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas M. C Donald
(Address) Boise
15. Filed Mar 4 1920 191 R. B. Lemmon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That ~~I attended~~ deceased ~~from~~ died suddenly March 3 1920, that I last saw h[er] alive on March 3 1920, and that death occured on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows: no Doctor Senility been getting weaker for the last two months
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas M C Donald M. D.
19..... (Address) Boise R 1 Husband

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 3/6 1920
20. UNDERTAKER: Schmidt & Heidenfelder — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 1204
File No. 29156
Registered No. 22

1. PLACE OF DEATH
County of Ada
City of Near Boise
If death occurs away from usual residence, give facts called for under special information.
(No.) Dolores Stone Hospital (St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Conroy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ... (Month) 1826 1 (Day) (Year)

7. AGE: 94 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E Summers
(Address) Boise Ida

15. Filed Mar 11 1920 L. O. Sims Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 10 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/1 1920 to 3/10 1920
that I last saw h.m alive on 3/8 1920
and that death occurred on the date stated above, at 1 A M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Fred A. Tillman M. D.
3/11 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: May 12 1920
20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29426

Registered No. 23

1. PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 8

Primary Registration District No. 2004

(No. So. Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry W. Mauss.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH: Sep (Month) 27 (Day) 1916 (Year)

7. AGE: 3 Yrs. 5 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): — — — —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Arthur O. Mauss.

11. BIRTHPLACE OF FATHER (State or Country): Missouri.

12. MAIDEN NAME OF MOTHER: Nora L. Ewing.

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur O. Mauss.
(Address) So Boise

15. Filed March 13 1920 L. P. Turner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ March 13 1920 ~~to~~ ~~19~~ that I last saw ~~him alive~~ on Mar 13 1920 and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:
Acute Heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner By

3/13 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Mar 15 1920.

20. UNDERTAKER: Summers & Crebs. ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2014
File No. 29457
Registered No. 24

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.
(No. Palatorium St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George F Cook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	White	Single

6. DATE OF BIRTH: Feb 24 (Month) (Day) 1912 (Year)

7. AGE: 8 Yrs. 0 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idg

10. NAME OF FATHER: George F Cook

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Jane Buffington

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. F Cook.
(Address) 1503 N. Main St.

15. Filed Mar 16 1920 L. R. Jones Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 14 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Mar 14 1920, to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Accidental drowning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Co. C. D.
3/15 1920 (Address) Boise Idg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Mar 16, 20

20. UNDERTAKER: Summers & Hicks — ADDRESS: Boise Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29428
Registered No. 25

1. PLACE OF DEATH
County of Ada
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8
Primary Registration District No. 2 w 4
(No. 1/2 mi So of Boise St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bessie M. Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widow)
6. DATE OF BIRTH: June 21 (Month) (Day) 1891 (Year)
7. AGE: 28 Yrs. 8 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wisconsin.
10. NAME OF FATHER: William F. Peterson
11. BIRTHPLACE OF FATHER (State or Country): Ohio.
12. MAIDEN NAME OF MOTHER: Ida M. Stewart
13. BIRTHPLACE OF MOTHER (State or Country): Illinois.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....
15. Filed Mar 18 1920 L. P. Sherman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 15 (Month) (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 12 1920 to March 15 1920
that I last saw h.. alive on March 15 1920
and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:
Uraemia
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Valvular Heart disease
(Duration) ~~...~~ yrs. 7 mos. ..... ds.
(Signed) R E Sherry M. D.
March 17 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Mar 18 1920.
20. UNDERTAKER: Summers & Keb. ADDRESS: Boise Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2942

Registered No. 26

1. PLACE OF DEATH.

County of Ada

City of near Boise

Registration District No. 8

Primary Registration District No. 2004

(No. near Col Custer Station St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Isabella Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: November (Month) 29 (Day) 1860 (Year)

7. AGE: 59 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Thomas Dunlap

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Carey D. Miller

(Address) R. D. #3, Boise Ida.

15. Filed Mar 18 1920 L. O. Sherman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1920, to March 16 1920, that I last saw her alive on March 16 1920, and that death occured on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes

..... (Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) Coma

..... (Duration ..... yrs. ..... mos. 2 ds.

(Signed) DeWitt C Hedges M. D.

3/17/1920. (Address) 1622 Warm St

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: 3/18 1920

20. UNDERTAKER: Schneider & Sieden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Soldiers Home Hospital)

File No. 29430

Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Eugene Guillott

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** M.

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Single (Write the word.)

6. **DATE OF BIRTH** Mar — 1843
(Month) (Day) (Year)

7. **AGE** 78 Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer): —

9. **BIRTHPLACE** (State or Country) Unknown

10. **NAME OF FATHER** Unknown

11. **BIRTHPLACE OF FATHER** (State or Country) Unknown

12. **MAIDEN NAME OF MOTHER** Unknown

13. **BIRTHPLACE OF MOTHER** (State or Country) Unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Haeger & Cobb.

(Address) Boise Idaho

15. Filed Mar 22 1920 L. C. Jamison
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Mar 21 1920
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 3/19 1920, to 3/21 1920
that I last saw ~~him~~ alive on 3/20 1920
and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis
Chronic

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred A. Tetwiler M. D.

3/22 1920 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Morris Hill Cem — **DATE OF BURIAL** Mar 23 20

20. **UNDERTAKER** Summers & Cobb. — **ADDRESS** Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

Bivver

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 29431
Registered No. 29

1. PLACE OF DEATH
County of Ada
City of So Boise
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Clare Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Single

6. DATE OF BIRTH: Mar 21 (Month) (Day) 920 (Year)

7. AGE: — Yrs. — Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Martin A. Nelson

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Albertina Johnston

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin A. Nelson
(Address) So Boise, Idaho.

15. Filed Mar 25 1920 L. C. Lemmon Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 24 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 21 1920 to Mch 24 1920 that I last saw her alive on Mch 23 1920, and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward J Bivver M. D.

3/25 1920 (Address) 303-304 McCarty Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Mar 26 1920
20. UNDERTAKER	**ADDRESS**
Semmens & Cobb.	Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8 4
Primary Registration District No. 2054
File No. 29432
Registered No. 30

1. PLACE OF DEATH

County of Ada
City of Van Boise
(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel J. Powers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Widower

6. DATE OF BIRTH (Month) (Day) 8 1841 (Year)

7. AGE 79 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. L. Burnett
(Address) Soldiers Home

15. Filed Mar 29 1920 L. O. Linn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/2 1920 to 3/29 1920 that I last saw him alive on 3/25 1920 and that death occurred on the date stated above at ..... M.
The CAUSE OF DEATH* was as follows:

Exhaustion / Senility

(Duration) ..... Yrs. ..... Mos. ..... ds.
Contributory (Secondary) Fracture Hip
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Putnam M. D.
3/29 1920 (Address) Owyhee

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Joplin Cemetery	Mar 31 1920
20. UNDERTAKER	ADDRESS
Summers & Hicks	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8 (Braxtan)
Primary Registration District No. 2024
File No. 29433
Registered No. 31

1. PLACE OF DEATH

County of Ada,
City of Boise
(No. County Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel L. Massey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W.	Widower

6. DATE OF BIRTH: March 11 (Month) 1849 (Day) (Year)

7. AGE: 71 Yrs. 0 Mos. 17 ds.
IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs O. N. Ellingson
(Address) Weiser, Ida.

15. Filed Mar 30 1920 L. P. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920 to Mar 28 1920 that I last saw him alive on Mar 28 1920, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Carbuncle

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Septicaemia

(Duration) yrs. mos. 4 ds.

(Signed) T. N. Braxtan M. D.

Mar 29 1920 (Address) 509 Empire B, Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Mar 31 1920

20. UNDERTAKER: Summers & Reed — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

8

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29434

Registered No. 32

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2074

Primary Registration District No.

(No. 3 Mile N.W. of Boise St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caroline Lundstrum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH Feb 23 1836
(Month) (Day) (Year)

7. AGE 84 Yrs. 0 Mos. 22 ds. 2

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William Lundstrum

(Address) R.4 Boise

15. Filed Mar 16 1920 L. P. Inman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 15 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 1 1920, to March 15 1920 that I last saw her alive on Feby 28 1920, and that death occurred on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 0 ds.

Contributory (Secondary) Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edward Bowe M. D.

3/16 1920. (Address) 303-304 McCarty Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Mar 17 1920
20. UNDERTAKER	ADDRESS
Summers & Krebs	Boise Idy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29435

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Star, Idaho St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza C. Snodgrass.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married.

6. DATE OF BIRTH Sept 6 1852
(Month) (Day) (Year)

7. AGE ....Yrs....Mos....ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER Joseph Snodgrass.

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Jane Hammond

13. BIRTHPLACE OF MOTHER (State or Country) Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise, Idaho.

15. Filed ....19.... Allen Hall Jr. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb - 6 - 1920
(Month) (Day) 19.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 19.., to Feby 6 19..20
that I last saw h.. alive on Feby 6 19..20
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Bright's Disease

Anasarca

(Duration) 1 Yrs. about 4 mos. ds.

Contributory (Secondary) Anasarca gomen

(Duration) ....yrs. 2 mos. ....ds.

(Signed) Allen Hall M. D.

2/7 1920 (Address) Star, Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Star Cemetery	2/8 1920
20. UNDERTAKER	ADDRESS
W McBratney	Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29436
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of Star
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ..... St.)

2. FULL NAME Mary Margaret Infant Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Mar (Month) 4 (Day) 1920 (Year)
7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 4 min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Star Idaho
10. NAME OF FATHER: Herman Miller
11. BIRTHPLACE OF FATHER (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Ada Hall.
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Herman Miller
15. Filed Mar 4 1920. Ada Hall RR Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch (Month) 4 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 4 1920, to Mar 4 1920, that I last saw her alive on Mar 4 1920 and that death occured on the date stated above, at 10.20 P.M.
The CAUSE OF DEATH* was as follows:
Premature Birth
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Ada Hall M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. — DATE OF BURIAL: Mar 5 1920
20. UNDERTAKER: Summers & Cobb. — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No.
File No. 29437
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Eagle
(No. 1½ Mile W of White Cross)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary C. Ford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 25 (Day) 1859 (Year)

7. AGE: 60 Yrs. 3 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Anna. Ills.

10. NAME OF FATHER: John Mead

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Sarah Jenkins

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): E. A. Ford
(Address): White Cross

15. Filed Mch. 11 1920. Fredric K. Lyons, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 19 1919, to Mar. 8 1920, that I last saw h[illegible] alive on Mar. 8 1920, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma-Uterus

(Duration) about 3 Yrs. mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Fredric K. Lyons M. D.
Mch 19 20 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence: Ada County

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery — DATE OF BURIAL: 3/12 1920

20. UNDERTAKER: Schreiber & Siddenfaden — ADDRESS: Boise

BYRNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada.

City of Eagle.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9

Primary Registration District No.

(No. ..... St.)

File No. 29438

Registered No.

If death occurred in a hospital, institution or camp, give NAME instead of street and number.

2. FULL NAME Sergel Mariece Sorter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Baby

6. DATE OF BIRTH: June (Month) 8 (Day) 1919 (Year)

7. AGE: ..... Yrs. 9 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) none.

9. BIRTHPLACE (State or Country): Dietrich Idaho

10. NAME OF FATHER: E. M. Sorter

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma.

12. MAIDEN NAME OF MOTHER: Elva Dixon.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Elva M Sorter,

(Address) Eagle. Idaho

15. Filed Mar 9th 1920

Fardonie K. Lewis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10 AM Mar 9 1920, to 11:50 A.M. Mar 9 1920 that I last saw h. alive on March 9th 1920, and that death occurred on the date stated above, at 11:50 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Catarrhal Broncho

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Nephritis

..... (Duration) ..... yrs. 4 mos. ..... ds.

(Signed) Fardonie K. Lewis M. D.

Mar 9 1920 (Address) Eagle, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Meridian, Idaho. DATE OF BURIAL: Mch 10 1920

20. UNDERTAKER: W. S. Mahrt ADDRESS: Meridian Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29440

Registered No. .....

1. PLACE OF DEATH.

County of .....

City of .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Jane Hepburn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 24 (Day) 1841 (Year)

7. AGE: 79 Yrs. 10 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Johnson Adams

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Violet Gilstrap

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Iona Sanders

(Address) Leonard, Idaho

15. Filed 3/31 1920

W. W. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Found dead in bed shortly after complaining of pain in her head

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Brown M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F.

DATE OF BURIAL: April 1 1920

20. UNDERTAKER: Young

ADDRESS: Leonard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29441

Registered No. —

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Adams

City of Council

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephan A. Robertson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. 12 (Month) 7 (Day) 1833 (Year)

7. AGE: 86 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robt Jennings

(Address) Council Idaho

15. Filed 2/21 1920

W M Brown
Local Registrar

SYMS - YORK CO., PTRS. & RBRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Feb 7 1920, that I last saw h.. alive on Feb 7 1920, and that death occured on the date stated above, at 5- P.M.

The CAUSE OF DEATH* was as follows:

Duodenal Ulcer

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) W M Brown M. D.

19..... (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pressler Cemetery

DATE OF BURIAL: 2/8 1920

20. UNDERTAKER: Young

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29442

Registered No.

1. PLACE OF DEATH

County of Adams

City of Meadows

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amos Gibler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: September (Month) 20 (Day) 1827 (Year)

7. AGE: 92 Yrs. 8 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Shipbuilding Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) St. Maine

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Anderson

(Address) New Meadows

15. Filed 2/24 1920

W M Boom
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1919, to Jan 2 1920 that I last saw him alive on Jan 2nd 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Brights Dis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. N. Gray M. D.

19..... (Address) New Meadows

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
On Anderson Place	19.....
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29443

Registered No.

Registration District No.

Primary Registration District No.

(No. ..... St.)

1. PLACE OF DEATH

County of Adams

City of New Meadows

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herschel Clay.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	white	Single (Write the word.)

6. DATE OF BIRTH: 2 (Month) 14 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Adams Co.

10. NAME OF FATHER: Loren J. Clay

11. BIRTHPLACE OF FATHER (State or Country): Riggins Idaho

12. MAIDEN NAME OF MOTHER: Flora M. Stone

13. BIRTHPLACE OF MOTHER (State or Country): Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed 3/21 19 20 — W M Broom, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 14 1920, to Feb 18 1920, that I last saw h. alive on Feb 18 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Uremia. Convulsions

Every hour Sometime Every

Five Minutes

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Mother had Albuminuria

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. N. Bragg M. D.

..... 19..... (Address) New Meadow Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meadow Cemetary	2-19 1920
20. UNDERTAKER	**ADDRESS**
[illegible]	New Meadows

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29444

Registered No.

Registration District No. 28 W. Bruce Council

Primary Registration District No.

(No. ..... St.)

1. PLACE OF DEATH

County of Adams

City of New Meadows

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lysmar F. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: Jan (Month) 23 (Day) 1848 (Year)

7. AGE: 72 Yrs. 2 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio (U.S.A.)

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lee Highley

(Address) New Meadows, Ida

15. Filed 3/31 1920 W. W. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 23 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1920, to Mar 23 1920, that I last saw h. im alive on Mar 19 1920, and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Uremia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Brights Chronic

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. N. Gragg M. D.

4-6 1920 (Address) New Meadows Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meadows Cemetery — DATE OF BURIAL: Mch 24 1920

20. UNDERTAKER: Lee Highley — ADDRESS: New Meadows.

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

#2

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29445

Registered No. 5222

Registration District No. 54

Primary Registration District No. 2101

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. 1 Terrace St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leah Gertrude Stine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Nov. (Month) 29 (Day) 1898 (Year)

7. AGE: 21 Yrs. 3 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pershing Idaho

10. NAME OF FATHER: Robert R. Stine

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Gertrude Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert R. Stine

(Address) Brunsfield Ida

15. Filed 3/7 1920. Fee Received

Dep. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1920 to Mar 7 1920 that I last saw her alive on Mar 7 1920 and that death occurred on the date stated above, at 4:15 a M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. H. Lyman M. D.

3/7 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State all her life yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida — DATE OF BURIAL: 3/9 1920

20. UNDERTAKER: J. H. Walker — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29446
Registered No. 325

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 424 So. 7th Ave. St.)

2. FULL NAME Ruth Adeline Bean

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 7 (Day) 1902 (Year)

7. AGE: 17 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pocatello Idaho

10. NAME OF FATHER Arthur B. Bean

11. BIRTHPLACE OF FATHER (State or Country) Massachusetts

12. MAIDEN NAME OF MOTHER Mary E. Lynch

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur B. Bean
(Address) 424 So. 7 ave

15. Filed Feb. 9 1920 [illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920 to Feb. 6 1920
that I last saw her alive on Feb. 6 1920
and that death occurred on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH* was as follows:
Influenza epidemic
(Duration) — Yrs. — mos. 9 ds.
Contributory (Secondary) Broncho-pneumonia
(Duration) — Yrs. — mos. 6 ds.

(Signed) W. T. Howard M. D.
2/9/1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death [illegible] yrs. [illegible] mos. [illegible] days. In the State [illegible] yrs. [illegible] mos. Pocatello days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Feb 11 1920

20. UNDERTAKER: H. L. McMahon ADDRESS: Pocatello, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29447
Registered No. 3230

Registration District No. .....
Primary Registration District No. .....

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. St. Anthonys Hos St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ichi Matsumura

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)
6. DATE OF BIRTH: July 1 1891 (Month) (Day) (Year)
7. AGE: 28 Yrs. 7 Mos. 10 ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Japan
10. NAME OF FATHER: Hikumatsu Ensura
11. BIRTHPLACE OF FATHER (State or Country): Japan
12. MAIDEN NAME OF MOTHER: Mat Known
13. BIRTHPLACE OF MOTHER (State or Country): Japan
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chiyono Matsumura
(Address) 215 N. 4th ave
15. Filed Feb 11 1920 P. D. Lucas Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 10 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1920 to Feb 10 1920 that I last saw her alive on Feb 9 1920 and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:
Influenza Pneumonia
.....
.....
.....(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
Feb 11 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? .....
Former or usual residence Japan

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Feb 12 1920
20. UNDERTAKER: H. L. McClain — ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29448
Registered No. 3233

Registration District No. 87
Primary Registration District No. 21 61

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 525 So 5th East St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pearl Nanney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Dec (Month) 14 (Day) 1883 (Year)

7. AGE: 37 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: J. M. Rourke

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Emma Bicktal

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Nanney
(Address) 525 So 5th Pocatello Ida.

15. Filed Feb 18 1920 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1920 to Feb 11 1920
that I last saw h[illegible] alive on Feb 11 1920
and that death occurred on the date stated above, at 12 20 P. M.

The CAUSE OF DEATH* was as follows:
Influenza, pneumonia
(Duration) 2 Yrs. mos. 5 ds.
Contributory (Secondary) Lagrippe
(Duration) Yrs. mos. ds.

(Signed) J. M. Kay M. D.
2-18 1920 (Address) Pocatello, Ida.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 17 yrs. mos. days. In the State 18 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Wyoming

19. PLACE OF BURIAL OR REMOVAL: Mt View — DATE OF BURIAL: Feb 17 1920

20. UNDERTAKER: H. L. McC[illegible] — ADDRESS: Pocatello Ida

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 216

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29449
Registered No. 33-36

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. 303 N. Pocatello St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Pete Sanchez

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Single

6. DATE OF BIRTH. Sept (Month) 17 (Day) 1915 (Year)

7. AGE: 5 Yrs. 4 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Eulalio Sanchez

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Julia Romiez

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Julia Sanchez
(Address): 303 N. Pocatello

15. Filed Feb 16 1920 — O. B. Keeler, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from little boy was dead when I came 191 to 191
that I last saw he alive on Feb 15th 1920
and that death occurred on the date stated above, at 7.05 M.

The CAUSE OF DEATH* was as follows:

flu pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary): none

(Duration) Yrs. mos. ds.

(Signed) [illegible] M. D.
Feb 16 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. 1 mos. .... days. In the State .... yrs. 1 mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence: Idaho Falls Idaho

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Feb 17 1920

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2950
Registered No. 3254

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. 411 N. 3rd Ave St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Murillo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Mexican	Single

6. DATE OF BIRTH. Dec (Month) 23 (Day) 1918 (Year)

7. AGE 1 Yrs. 2 Mos. 12 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Blackfoot Ida

10. NAME OF FATHER Amado Murillo

11. BIRTHPLACE OF FATHER (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Concepcion

13. BIRTHPLACE OF MOTHER (State or Country) Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Amado Murillo
(Address) 411 N. 3rd ave

15. Filed Mar. 8 1920 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4th 1920 to March 6th 1920 that I last saw him alive on March 6 1920 and that death occurred on the date stated above, at 1¼ A. M.

The CAUSE OF DEATH was as follows:

Pneumonia

(Duration) .... Yrs. .... mos. 20 ds.

Contributory (Secondary) Influenza

(Duration) .... Yrs. .... mos. .... ds.

(Signed) C. E. Baugh M. D.

3-8 1920 (Address) 944 W. Fremont

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 8 mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence Blackfoot Ida

19. PLACE OF BURIAL OR REMOVAL Mt View — DATE OF BURIAL Mar. 8 1920

20. UNDERTAKER K. L. McClain — ADDRESS Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32431
Registered No. 3240

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. St. Anthonys St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Soren K Engh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Single

6. DATE OF BIRTH. ..... (Month) ..... 1 ..... (Day) ..... (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Tailor.

9. BIRTHPLACE (State or Country) Denmark.

10. NAME OF FATHER Jens N Sorrensen

11. BIRTHPLACE OF FATHER (State or Country) Denmark.

12. MAIDEN NAME OF MOTHER Mary Branksalm

13. BIRTHPLACE OF MOTHER (State or Country) Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Sorensen
(Address) 1072 So 4 East S. L. C. Utah

15. Filed Feb 26 1920 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 17th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 13th 1920 to Feb. 17th 1920
that I last saw him alive on Feb. 16th 1920
and that death occurred on the date stated above, at 3. a. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Influenza

(Duration) ..... Yrs. ..... mos. 3. ds.

(Signed) E. A. Young M. D.

Feb 26 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL ..... 191..

20. UNDERTAKER H. L. McHan — ADDRESS Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 326

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24
Primary Registration District No. 2161
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Vern Neyman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male.
4. COLOR OR RACE: white.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.
6. DATE OF BIRTH: March (Month) 13 (Day) 1920 (Year)
7. AGE: ..... Yrs. ..... Mos. 3 ds. IF LESS than 1 day how many .... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE: 1153 So 4 ave. (Street or Country) Pocatello Idaho. Neyman
10. NAME OF FATHER: Mellevell. Neyman
11. BIRTHPLACE OF FATHER (State or Country): Kentucky.
12. MAIDEN NAME OF MOTHER: May Monillison
13. BIRTHPLACE OF MOTHER (State or Country): Ohio.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Orpha Monillison
(Address) American Falls.
15. Filed March 17 1920. O. P. Steele Local Registrar

MEDICAL CERTIFICATE OF DEATH *

16. DATE OF DEATH: March (Month) 16 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3-10 1920 to 3-15 1920 that I last saw h.-.. alive on 3-15 1920 and that death occurred on the date stated above, at 5.30 A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
.....
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Influenza in mother
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
3/17 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos. 3 days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? Pocatello.
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: American Falls Ida. DATE OF BURIAL: March 18 1920
20. UNDERTAKER: H. L. McFan ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32453
Registered No. 3268

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 1153 So. 4th ave St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Day Meyman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: July (Month) 4 (Day) 1902 (Year)

7. AGE: 17 Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Neal Danielson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Orpha Lish

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Orpha Danielson
(Address) American Falls

15. Filed Mar. 17 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1920 to March 16 1920 that I last saw h[illegible] alive on March 16 1920 and that death occurred on the date stated above, at 10:25 P. M.

The CAUSE OF DEATH* was as follows:

Pericarditis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Influenza

(Duration) ..... Yrs. ..... mos. 15 ds.

(Signed) [illegible] M. D.

3/17 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. 8 mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death? [illegible]

Former or usual residence American Falls

19. PLACE OF BURIAL OR REMOVAL: American Falls Ida — DATE OF BURIAL: Mar 18. 1920

20. UNDERTAKER: W. L. McHan — ADDRESS: Pocatello Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 29454
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Bancroft
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phyllis Marie Sorensen.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: February 20 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bancroft Idaho.

10. NAME OF FATHER: Milton B. Sorensen

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Florence G. Gordon

13. BIRTHPLACE OF MOTHER (State or Country): Central Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Milton B. Sorensen By O. L.
(Address) Bancroft Idaho.

15. Filed MAR 11 1920 19.....
O. L. Lindquist
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 20 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1920 to March 20 1920 that I last saw her alive on March 20 1920 and that death occurred on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows:

acute Dio-colitis.

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Cardiac asthenia

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Oscar O. Lindquist M. D.

3/20 1920 (Address) Bancroft Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bancroft Idaho — DATE OF BURIAL: 3/22 1920

20. UNDERTAKER — ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8H
Primary Registration District No. 8161
File No. 29455
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Chesterfield
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur LeRoy Kendrom.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: February 8th 1920
(Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 52 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bancroft Idaho.

10. NAME OF FATHER: Jack Kendrom

11. BIRTHPLACE OF FATHER (State or Country): at large.

12. MAIDEN NAME OF MOTHER: Lillian Croft.

13. BIRTHPLACE OF MOTHER (State or Country): Hailey Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jack Kendrom.
(Address) Chesterfield

15.
Filed ..... 19 .....
O. V. Linhardt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 31 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1920, to March 30 1920, that I last saw h.... alive on March 30 1920, and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Strangulated right inguinal direct hernia.

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Peritonitis
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) O. V. Linhardt M. D.
3/31 1920 (Address) Bancroft Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chesterfield — DATE OF BURIAL: Apr 1 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 2945
Registered No. 3252

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. Fargo Apt. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marguerite Buchholz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Widowed

6. DATE OF BIRTH Dec 6th 1842
(Month) (Day) (Year)

7. AGE 77 Yrs. 3 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Mathias Eis

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. H. Hayden
(Address) Fargo Apt City

15. Filed Apr 2, 1920 O. R. Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2 20
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1920 to April 2 1920 that I last saw her alive on Apr 1 1920 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) Few Yrs. — mos. — ds.

Contributory (Secondary) Hypostatic pneumonia

(Duration) — yrs. — mos. 3 ds.

(Signed) W. F. Howard M. D.

4/2 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Omaha Neb	Apr 7 1920
20. UNDERTAKER Thurmond & Hall	**ADDRESS** City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 329458
Registered No. 32-80

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 121 West Bonnor St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lovell Allen Thomas

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: September 7 (Month) (Day) 1917 (Year)

7. AGE: 2 Yrs. 6 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Dillon Montana

10. NAME OF FATHER: Evan W. Thomas

11. BIRTHPLACE OF FATHER (State or Country): Twin Bridges Mont

12. MAIDEN NAME OF MOTHER: Florence Pidsonght

13. BIRTHPLACE OF MOTHER (State or Country): Paris Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Evan W Thomas

(Address) Pocatello Ida.

15. Filed Apr 1, 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1920, to Apr. 1st 1920, that I last saw him alive on March 31st 1920, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. N. Sprague M. D.

Apr 1. 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dillon Montana — DATE OF BURIAL: 19

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 21 61
File No. 29459
Registered No. 3279

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary D Harrison
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 24 (Day) 1884 (Year)

7. AGE: 35 Yrs. 8 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logan Utah

10. NAME OF FATHER: F. C. Christensen Sr

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Elsie Miller

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Harrison
(Address) Bancroft Idaho

15. Filed Mar 30 1920 — R. L. Steed, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 28 1920 to Mar 30 1920 that I last saw h... alive on Mar. 30 1920 and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:
Nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Deering M. D.
Mar 30 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bancroft Idaho — DATE OF BURIAL: Mar. 1920

20. UNDERTAKER: Schumacher & Hill — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2161
File No. 29461
Registered No. 3277

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. St. Anthony Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen May Lambert
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar 9 th (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. X Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Chas - Lambert

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Dolly Clemens

13. BIRTHPLACE OF MOTHER (State or Country): Arizona

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Lambert
(Address) 1104 S. 5. City

15. Filed Mar 24 1920 O. B. Neely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 24 th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 17 1920, to Mch 24th 1920, that I last saw her alive on Mch 24 1920 and that death occurred on the date stated above, at 6:20 M.
The CAUSE OF DEATH* was as follows:

Encephalitis - Influenzal

(Duration) Yrs. 0 mos. 10 ds.
Contributory (Secondary) Oophorogenetic Paralysis
(Duration) yrs. mos. 7 ds.

(Signed) F. M. Sprague M. D.
3-24 1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) St. Anthony's
At place of death ... yrs. ... mos. 3 days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? 1104 S. 5th Pocatello Ida.
Former or usual residence 1104 S. 5th " "

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Mar 25 1920
20. UNDERTAKER: Schumacher & Hart — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 22468
Registered No. 3276

Registration District No. 54
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 807 So. Harrison St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin Dwell Chase

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widower
6. DATE OF BIRTH. June 17 1838
(Month) (Day) (Year)
7. AGE: 82 Yrs. 2 Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Marble Cutter
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Indiana
10. NAME OF FATHER: Elfield Chase
11. BIRTHPLACE OF FATHER (State or Country): Maine
12. MAIDEN NAME OF MOTHER: Elizabeth Dwell
13. BIRTHPLACE OF MOTHER (State or Country): Maine
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marietta Chase
(Address) 807 So. Harrison
15. Filed Mar 24 1920 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 23 1920
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h.. alive on ..... 191....
and that death occurred on the date stated above, at 5:45 P. M.
The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
Cardio Valvular Disease
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... Yrs. ... mos. ... ds.
(Signed) [signature] M. D.
3-24 1920 (Address) Pocatello
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 2 mos. 12 days. In the State....yrs. 2 mos. 12 days
Where was disease contracted if not at place of death?
Former or usual residence Wyoming

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Mar 25 1920
20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29463
Registered No. 3275

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. ....., ... St.)

2. FULL NAME John Askville Lorimer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: [illegible] 22 1839 (Month) (Day) (Year)

7. AGE: 81 Yrs. 11 Mos. — ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: John Lorimer

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Elizabeth Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Harvey Lorimer
(Address) 536 So. 4th Ave.

15. Filed Mar 22 1920. O. B. Steele Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 22 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1920 to Mar 22 1920 that I last saw him alive on Mar 21 1920 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia produced by irritation to diaphragm
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) acute alcoholism
..... (Duration) Both Yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
Mar 22 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 4 mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death? .....
Former or usual residence Nebraska

19. PLACE OF BURIAL OR REMOVAL: Kearney Neb. DATE OF BURIAL: March 1920

20. UNDERTAKER: H. E. Nettan. ADDRESS: 215 So Main

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29464

Registered No. 3274

Registration District No. 84

Primary Registration District No. 21 Bat

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. Legislative Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hester E. Norton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) 16 (Day) 1899 (Year)

7. AGE: 21 Yrs. 1 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Preston Ida

10. NAME OF FATHER: Charles A. Norton

11. BIRTHPLACE OF FATHER (State or Country): Provo City Utah

12. MAIDEN NAME OF MOTHER: Mary A Maughan

13. BIRTHPLACE OF MOTHER (State or Country): Tooele Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. N. Norton

(Address) Preston Ida

15. Filed Mar 21 1920 O B Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14 1920, to March 20 1920, that I last saw h alive on 3/20 1920, and that death occurred on the date stated above, at 9:30 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis obstruction

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) J. N. Lynn M. D.

3/20 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: 3/22 1920

20. UNDERTAKER: J. H. Walker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29465
Registered No. 3273

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock.
City of Pocatello.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Lee McCullough.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married.
6. DATE OF BIRTH. Oct (Month) 16 (Day) 1893 (Year)
7. AGE: 27 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Illinois.
10. NAME OF FATHER: Leander McCullough
11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania
12. MAIDEN NAME OF MOTHER: Elizabeth Turner
13. BIRTHPLACE OF MOTHER (State or Country): Illinois
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. N. Peterson
(Address) 345 N. Buchanan
15. Filed Mar 22 1920 O. B. Steel Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 19 1920 to Mar 20 1920
that I last saw him alive on Mar 19 1920
and that death occurred on the date stated above, at 9.40 A.M.
The CAUSE OF DEATH* was as follows:

Typhoid fever
Exhaustion

(Duration) ..... Yrs. ..... mos. 17 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) O. B. Steel M. D.
(Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. 1 days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence Idahome.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 3/23 1920
20. UNDERTAKER: H. L. McEtan — ADDRESS: 215 So Main

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 329466

Registered No. 3272

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2 16 1

(No. 1 Lynn Nesbit St.)

2. FULL NAME C. C. Shepard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) Married

6. DATE OF BIRTH April 22 1884
(Month) (Day) (Year)

7. AGE 36 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Government Trapper

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE Springfield S. D.
(State or Country)

10. NAME OF FATHER Geo. Shepard

11. BIRTHPLACE OF FATHER North Carolina
(State or Country)

12. MAIDEN NAME OF MOTHER Melicia Richardson

13. BIRTHPLACE OF MOTHER North Carolina
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. C. Shepard

(Address) American Falls

15. Filed Mar 21 1920 O. B. Steed
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 20 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1920, to 3 20 1920, that I last saw h.im alive on 3 20 1920, and that death occurred on the date stated above, at 9:45 P. M.

The CAUSE OF DEATH* was as follows:

Volvulus

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. N. Lynn M. D.

Mar 20 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL American Falls Ida | DATE OF BURIAL 3 24 1920

20. UNDERTAKER P. D. Parker ADDRESS Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29467

Registered No. 3271

Registration District No. 84

Primary Registration District No. 2461

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(If not in city or town give name of township)
If death occurs away from usual residence, give facts called for under special information.

(No. Lynn Boo 5th St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joshua Jones.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 28 1853 (Month) (Day) (Year)

7. AGE: 66 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Jones
(Address) Pocatello Ida

15. Filed Mar 19 1920 — O. B. Steel, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 19 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920 to Mar 19 1920 that I last saw h[illegible] alive on Mar 18 1920, and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:
Abscess of Right Lung
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Debility old age
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Lynn M. D.
3/20 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Ida
DATE OF BURIAL: Mar 20 1920

20. UNDERTAKER: Brawner.
ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29468

Registered No. 3270

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. 340 South 8th St.)

Registration District No. 8

Primary Registration District No. 2164

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Sumner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: December 4 (Month) (Day) 1918 (Year)

7. AGE: 1 Yrs. 3 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Upper Utah

10. NAME OF FATHER: J. W. Sumner

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Kathryn Alger

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Sumner

(Address) 340 So 8th

15. Filed Mar 18 1920 O. P. Neely Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 17 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1920, to March 17 1920, that I last saw h..... alive on March 17 1920, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

a Pulmonary Congestion

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Mar 18 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View Cem	Mar 19 1920
20. UNDERTAKER	**ADDRESS**
Schumacher & Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32469

Registered No. 3269

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 7 Ward

(No. 1 [illegible] Ave. or Street) St.)

2. FULL NAME Sadie Beach Carr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1894 (Year)

7. AGE: 26 Yrs. 26 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: T. J. Beach

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henry Carr

(Address) Pocatello Ida

15. Filed Mar 17 1920 O. B. Steele Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1920 to 3/16 1920, that I last saw her alive on 3/16 1920, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Post Operative

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary) Operation,

(Duration) yrs. mos. ds.

(Signed) O. W. Lyon M. D.

3/17 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: 3/18 1920

20. UNDERTAKER: W. H. Parker — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29470
Registered No. 3266

1. PLACE OF DEATH Dr Miller

Registration District No. 84
Primary Registration District No. 216
(No. Residence Inkom St.)

County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Ann Cornwall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: January (Month) 20 (Day) 1878 (Year)

7. AGE: 42 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Ogden Utah

10. NAME OF FATHER: Levi L. Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Ellen Larmoder

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John I Cornwall
(Address) Inkom

15. Filed Mar 18 1920 O K Reedy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 3 1920, to Mch 16 1920, that I last saw her alive on Mch 15 1920, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Pleurisy
(Duration) ..... Yrs. ..... mos. 20 ds.
Contributory (Secondary) Gall Stones
(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) J. F. Miller M. D.
19 ..... (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Inkom Idaho	March 19 1920
20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2947

Registered No. 3265

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. Lynn Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 216

2. FULL NAME Infant Mayes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 15th (Day) 1920 (Year)

7. AGE: ... Yrs. ... Mos. ... ds.

IF LESS than 1 day how many 20 hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: James J. Mayes

11. BIRTHPLACE OF FATHER (State or Country): Mon — Mar 15 1920

12. MAIDEN NAME OF MOTHER: Ethel Beach

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James J. Mayes

(Address) Pocatello Idaho

15. Filed Mar 17 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1920, to Mar 15 1920

that I last saw him alive on Mar 15 1920

and that death occurred on the date stated above, at 5:45 M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Lyon M. D.

Mar 15 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 6 hrs. ~~days~~ In the State ... yrs. ... mos. 6 hrs. ~~days~~

Where was disease contracted if not at place of death? Premature Birth

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Highland Park — DATE OF BURIAL: Mar 19 20

20. UNDERTAKER: [illegible] — ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 29472
Registered No. 3264

1. PLACE OF DEATH
County of Bannock
City of Pocatello.
(No. 830; West Fremont St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas W Miller.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: Mar. (Month) 21 (Day) 1841 (Year)

7. AGE: 79 Yrs. 11 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: Chas. Miller

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Cromwell.
(Address) 830 West Fremont

15. Filed Mar 15 1920 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 6, 1920 to Mar 14 1920 that I last saw h. alive on Mar 12 1920 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

General debility
and malnutrition

(Duration) ..... Yrs. ..... mos. 3 weeks ds.

Contributory (Secondary) old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

3/15 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida. DATE OF BURIAL: Mar 17 1920

20. UNDERTAKER: [illegible] ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29473
Registered No. 3263

1. PLACE OF DEATH

County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 24
(No. Tyson Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Meyers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar 15 (Month) (Day) 1920 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many 20 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Idaho
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James J. Meyers

11. BIRTHPLACE OF FATHER (State or Country): Mar 15 1920 — Mar 15 1920

12. MAIDEN NAME OF MOTHER: Ethel Beach

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James J. Meyers
(Address) Pocatello Idaho

15. Filed Mar 17 1920 O. R. Sleeper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 15 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1920 to Mar 15 1920 that I last saw her alive on Mar 15 1920, and that death occurred on the date stated above, at 9:10 P.M.
The CAUSE OF DEATH* was as follows:
Premature Birth

....(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
....(Duration) ....yrs....mos....ds.

(Signed) J. V. Thomas M. D.
Mar 15 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos. 6 hrs. days in the State ....yrs....mos. 6 hrs. days
Where was disease contracted if not at place of death? Premature Birth
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cemetery Idaho — DATE OF BURIAL: Mar 17 1920
20. UNDERTAKER: Thomason & Hart — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Dr Howard

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 3229474
Registered No. 3262

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 440 South Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Early

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Infant

6. DATE OF BIRTH
March (Month) 11 (Day) 1920 (Year)

7. AGE
— Yrs. — Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Pocatello Idaho

10. NAME OF FATHER
Robert E. Early.

11. BIRTHPLACE OF FATHER
(State or Country) Ill

12. MAIDEN NAME OF MOTHER
Miss Edna Nuffer

13. BIRTHPLACE OF MOTHER
(State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. E. Early.
(Address) 440 So. Main

15. Filed Mar 15 1920 W. F. Howard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11 1920 to Mar 14 1920 that I last saw her alive on Mar 13 1920 and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:
Transition
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Asthenia
(Duration) yrs. mos. 3 ds.

(Signed) W. F. Howard M. D.
3/14/1920 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View Cem	Mar 15 1920
20. UNDERTAKER	**ADDRESS**
Schumacher & Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

M V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

84 161 3269 — 29475

State of Id... BOARD OF ... Bureau of Vital ... File No. 32... Registered No. ...

PLACE OF DEATH

(a) County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 216

(No.) Tuxmess Gravel Pit St. Pocatello

If death occurre... pital, institution... give its NAME ... street and numb...

2. FULL NAME Paul Bowman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 22 (Day) 1908 (Year)

7. AGE: 11 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Knoxville Tenn

10. NAME OF FATHER: John J. Bowman

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Lettie E. Hooper

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John J. Bowman
(Address): 331 N. 13th St.

15. Filed: Mar. 15 1920 — [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 14 (Day)

17. I HEREBY CERTIFY, That I attended dec... 191... to ...
that I last saw h... alive on ...
and that death occurred on the date stated above, at 4...

The CAUSE OF DEATH* was as follows:
Accidental by cave in [illegible] Sand pit.
(Duration) ... Yrs. ... mos. ...
Contributory (Secondary) ...
(Duration) ... Yrs. ... mos. ...
(Signed) ... M.D.
3-16-1920 (Address) 212 So 8th Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 4 mos. ... days. In the State 6 yrs. ... mos. ...
Where was disease contracted if not at place of death? ...
Former or usual residence: Knoxville, Tenn.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF ... Mar 16

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. O. S. [illegible] St.)
File No. 29476
Registered No. 3260

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew L. Ramstrom
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug 19th (Month) (Day) 1851 (Year)

7. AGE: 68 Yrs. 6 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Employee O. S.
(b) General nature of industry, business or establishment in which employed (or employer): + L R.R.

9. BIRTHPLACE (State or Country): Ekeby Sweden

10. NAME OF FATHER: Andrew P. Ramstrom

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mina - Palin

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew L Ramstrom
(Address) 1001 S. Harrison

15. Filed Mar 15 1920 Entered Supplemental View
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Struck by a Rail Road engine #4737 accident
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E E Houde acting Coroner M. D.
March 15 1920. (Address) 358 W. Center St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Mar 16 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 23477
Registered No. 3258

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 339 No 4 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gracie Juanita Alexander

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: Nov. 30 (Month) (Day) 1903 (Year)
7. AGE: 16 Yrs. 2 Mos. 21 ds. IF LESS than 1 day how many ... hrs. or ... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Boise - Ida
10. NAME OF FATHER: C E Alexander
11. BIRTHPLACE OF FATHER (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Lucie Nous
13. BIRTHPLACE OF MOTHER (State or Country): Louisville Mo
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Alexander
(Address) Pocatello Ida
15. Filed Mar. 13 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 12 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 6 1920 to March 12 1920 that I last saw h[illegible] alive on March 12 1920 and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Epilepsy
(Duration) 2 Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Asa Newton M. D.
Mar 13 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] Cemetery | DATE OF BURIAL: 3/15 1920
20. UNDERTAKER: [illegible] Walker | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29478
Registered No. 325

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Lava
If death occurs away from usual residence, give facts called for under special information.
(No. Riverside Hotel St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wesley T. Hawks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.)
Male	white	Married Widower

6. DATE OF BIRTH. May (Month) 10 (Day) 1 (Year)

7. AGE 32 Yrs. 10 Mos. 2 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Virginia

10. NAME OF FATHER Wm. Hawks

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Flora Baumgardner

13. BIRTHPLACE OF MOTHER (State or Country) Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew C. Hawks
(Address) Fremonton Utah

15. Filed 3-13 1920 [illegible] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1920 to Jan 12 1920 that I last saw him alive on Jan 12 1920 and that death occurred on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Bilobar
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary) Influenza
(Duration) Yrs. mos. 7 ds.

(Signed) O. P. Fleming M. D.
3-12 1920 (Address) Lava Hot Springs, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 1 mos. ....days. In the State....yrs. 1 mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence Rock Springs Wyo.

19. PLACE OF BURIAL OR REMOVAL Fremonton Utah — DATE OF BURIAL May 12 1920

20. UNDERTAKER H. L. McClain — ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

29479

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 91
Primary Registration District No. 2168
(No. .... St.)

File No. .....
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nezperce
City of Elk River

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Meeks

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. January (Month) 23 (Day) 1901 (Year)

7. AGE: 19 Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Emmons Cram

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Lizzie Erbinger

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs A. Cunningham Sister
(Address) Elk River Ida

15. Filed April 16 1920 Ira M. Cunningham Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 10 1920, to Feb 17th 1920, that I last saw her alive on February 17 1920 and that death occured on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:
Influenza complicated with Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) F. P. McCornick M. D.
1920 (Address) Elk Russell

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River — DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: Morris — ADDRESS

FORM V. S. No. 5-25 M. 1-19.

Dr Wm Newton

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2-61

(Name) St Anthony Hospital

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33480

Registered No. 3293

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angelo Cuozzo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word.)

6. DATE OF BIRTH Exact date unknown (Month) (Day) 1852 (Year)

7. AGE 68 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER Michael Cuozzo

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Zenna

(Address) Pocatello Idaho

15. Filed Mar. 13 1920 Fr Fowler Jr Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar 10 (Month) (Day) 1920 (Year)

17. "I HEREBY CERTIFY, That I attended deceased from Mar 5 1920 to Mar 10 1920 that I last saw h~~im~~ alive on Mar 10 1920, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Acute dilatation of heart

(Duration) yrs. mos. 2 ds.

(Signed) Wm. Newton M. D.

Mar 12 1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View Cem **DATE OF BURIAL** Mar 13 1920

20. UNDERTAKER Schumacher & Harp **ADDRESS** Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 23481
Registered No. 3233

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. General Hospital St.)

2. FULL NAME Dr. Grant Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH. Feb (Month) 23 (Day) 1920 (Year)

7. AGE: ... Yrs. ... Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Gen Hos

10. NAME OF FATHER: Pearley Hall

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Nella Barker

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nella Hall
(Address) General Hos

15. Filed Mar 8 1920 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 7 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8th 1920 to Mar 8th 1920
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary)

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) [signature] M. D.
Mar 8th 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 1 mos. days In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem, DATE OF BURIAL: Mar 8. 1920

20. UNDERTAKER: H. L. McHan ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84 — 29482
Primary Registration District No. 2161
File No. 32
Registered No. 3252

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. 129 So. 10th Ave. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin Walter Puckett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH. April 25 1866
(Month) (Day) (Year)

7. AGE 54 Yrs. 10 Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work Salesmen
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Benjamin Puckett

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Emelin Hadford

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth Puckett
(Address) 129 So 10th Ave

15. Filed Nov 8 1920 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 6 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 2 1920 to Feb 6 1920
that I last saw h alive on Feb 6 1920
and that death occurred on the date stated above, at 1.40 P. M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia

(Duration) one Yrs. mos. 4 ds.
Contributory (Secondary) Endocarditis

(Duration) 3 Yrs. mos. ds.
(Signed) J. M. Mahan M. D.
3 1920 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 9 yrs. mos. days. In the State 9 yrs. mos. days
Where was disease contracted if not at place of death? .....
Former or usual residence Colorado

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Cem	Nov 9 1920

20. UNDERTAKER	ADDRESS
A. Duncan	Pocatello Ida

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2464
File No. 29483
Registered No. 3251

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. General Hospital St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Woolrich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): unknown (Pauper)
6. DATE OF BIRTH: unknown (Month) (Day) 1 (Year)
7. AGE: about 65 near as known Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): unknown
10. NAME OF FATHER: unknown
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) General Hospital
(Address) Pocatello Idaho
15. Filed Mar 5, 1920 E. E. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 5th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st 1920 to March 5 1920 that I last saw h.— alive on March 5 1920 and that death occurred on the date stated above, at 4:30 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia
Bronchial
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. 3 ds.
(Signed) John H. Bowman M. D.
Mar 5 19 20 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Mar 5 1920
20. UNDERTAKER: Hummacher & Hall — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

File No. 29484
Registered No. 3250

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Johnson Dale
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: December 23 1910 (Month) (Day) (Year)

7. AGE: 9 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Bingham Utah

10. NAME OF FATHER: Ed Johnson

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Utah

12. MAIDEN NAME OF MOTHER: Mary Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W. C. Dale
(Address) 731- So Main

15. Filed Mar 9 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 4 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S S Ferguson Coroner
3/9/1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: March 9 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

CERTIFICATE OF DEATH 29486

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3248

Registration District No. 84
Primary Registration District No. 2161
(No. Inkom Idaho St.)

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie M. Richardson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: May 21 1859 (Month) (Day) (Year)

7. AGE: 63 Yrs. 9 Mos. 4 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indianna

10. NAME OF FATHER: J. H. Mendenhall

11. BIRTHPLACE OF FATHER (State or Country): Indianna

12. MAIDEN NAME OF MOTHER: Mary Lane

13. BIRTHPLACE OF MOTHER (State or Country): Indianna

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grace Hughes
(Address) Inkom Idaho

15. Filed Feb 26 1920 O. R. Steely
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 25 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1919 to Feb 24 1920
that I last saw her alive on Feb 24 1920
and that death occurred on the date stated above, at 10.00 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver
(Cancer of Liver)

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary): non

(Duration) Yrs. mos. ds.

(Signed) J. F. Miller M. D.
2/26 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. mos. days. In the State 5 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Gillman City Missouri

19. PLACE OF BURIAL OR REMOVAL: Gillman City Mo. DATE OF BURIAL: Feb 27 1920

20. UNDERTAKER: H. L. McHAN ADDRESS: POCATELLO, IDAHO

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

29487

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3247

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special nformation.
(No. General Hosp. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe Wallace

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. Not Known (Month) (Day) 1 (Year)

7. AGE: 88 Yrs. Mos. ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Indian Scout
(b) General nature of industry, business, or establishment in which employed (or employer): and guide

9. BIRTHPLACE (State or Country): Colorado.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Wakell
(Address) Hart, Hall, Ida.

15. Filed Feb. 26 1920 O. B. Steely Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 25 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1919 to Feby 25 1920 that I last saw h. alive on Feby 1920 and that death occurred on the date stated above, at 9.30 A. M.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) W. L. Wakell M. D.
Feby 26 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State 35 yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Feb 28 1920

20. UNDERTAKER: H. L. McClain ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

29488 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 25
Registered No. 2246
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock
City of Pocatello.
If death occurs away from usual residence, give facts called for under special information.

(No. General Hospl St.)

2. FULL NAME Lydia May Shoobridge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Married

6. DATE OF BIRTH. March 19 (Month) (Day) 1901 (Year)

7. AGE 18 Yrs. 11 Mos. 4 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Nurse
(b) General nature of industry, business, or establishment in which employed (or employer) Washington

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Wm. E. Shoobridge

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Kinsey

13. BIRTHPLACE OF MOTHER (State or Country) South Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mary Shoobridge
(Address) Union Mills Wash.

15. Filed Feb. 23 1920 T. P. Lucas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
POCATELLO, IDAHO Feb 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1920 to Feb 22 1920
that I last saw her alive on Feb 22 1920
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(Duration) .... Yrs. .... mos. 6 ds.

Contributory (Secondary) None

(Duration) .... Yrs. .... mos. .... ds.

(Signed) W. W. Brothers M. D.
Feb 22 1920 (Address) POCATELLO, IDAHO

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 4 mos. ....days. In the State ....yrs. 4 mos. ....days
Where was disease contracted if not at place of death? ....
Former or usual residence Union Mills Washington

19. PLACE OF BURIAL OR REMOVAL Olympia Washington — **DATE OF BURIAL** Feb 23 1920

20. UNDERTAKER H. L. McHAN — **ADDRESS** POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

29489

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 32
Registered No. 3245

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W L Crozier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
X January 24 1871
(Month) (Day) (Year)

7. AGE
49 Yrs. - Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Drayer man
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
X (State or Country) Big Lake, Minn

10. NAME OF FATHER Robert P. Crozier

11. BIRTHPLACE OF FATHER
X (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Ruth DeWees

13. BIRTHPLACE OF MOTHER
X (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C R Blehub
(Address) Twin Falls Ida

15. Filed Feb 23 1920 J R Steed
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lung
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S B Ferguson Coroner M. D.
2-22-1920 (Address) 202 So 8th Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence X Twin Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Idaho	Feb 23 1920
20. UNDERTAKER	**ADDRESS**
Moran	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

29490

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3247

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 315 So. Arthur Ave St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ann Mariah Gumph

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widow

6. DATE OF BIRTH. Oct (Month) 7 (Day) 1830 (Year)

7. AGE: 90 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James Lefler

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rhoda Frazer

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Rhoda Wilson
(Address) 315 So. arthur ave

15. Filed Feb 23 1920 O. B. Steen Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 20 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1920 to Feb 20 1920 that I last saw her alive on Feb 20 1920 and that death occurred on the date stated above, at 11.40 P. M.

The CAUSE OF DEATH* was as follows:
Dilitation of heart
(Duration) 10 Yrs. mos. ds.
Contributory (Secondary) Senility
(Duration) 20 Yrs. mos. ds.

(Signed) O. B. Steen M. D.
Feb 23 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State 14 yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence Des moines Iowa

19. PLACE OF BURIAL OR REMOVAL: Des moines Iowa
DATE OF BURIAL: .... 191...

20. UNDERTAKER: H. L. McHAN
ADDRESS: POCATELLO, IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

29491

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3243

CERTIFICATE OF DEATH

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 1 General Hosp. St.)
2. FULL NAME Genichi Abe.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Japanese	Widower

6. DATE OF BIRTH. Not Known 1890
(Month) (Day) (Year)

7. AGE about 30 Yrs. Mos. ds.
30
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Japan.

10. NAME OF FATHER Genkichi Abe.

11. BIRTHPLACE OF FATHER (State or Country) Japan.

12. MAIDEN NAME OF MOTHER Not Known.

13. BIRTHPLACE OF MOTHER (State or Country) Japan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) K. Masumato
(Address) Tyhee Idaho

15. Filed Feb 20 1920 J. R. Lewis Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb 19 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 14th 1920 to February 19th 1920
that I last saw him alive on February 19th 1920
and that death occurred on the date stated above, at 7.55 P. M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) James J. O'Connor D.S. M. D.
2-29-20 (Address) Church & White Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State 5 yrs. .... mos. .... days Pocatello
Where was disease contracted if not at place of death?
Former or usual residence Tyhee.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Cem	Feb 20 1920

20. UNDERTAKER	ADDRESS
A. E. McHan.	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

29492

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 32
Registered No. 3242

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. General Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Riggs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Feb (Month) 15 (Day) 1920 (Year)

7. AGE: ....Yrs. ....Mos. 4 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER C. L. Riggs

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Ella V. Hawkes

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake City, Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Riggs
(Address) Pocatello, Idaho

15. Filed Feb 19 1920 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16th 1920 to Feb 19 1920
that I last saw him alive on Feb 18 1920
and that death occurred on the date stated above, at 4 a.m. M.

The CAUSE OF DEATH* was as follows:
Premature birth
7 mos.
(Duration) .... Yrs. .... mos. 4 ds.
Contributory (Secondary) Influenza mother
(Duration) .... Yrs. .... mos. .... ds.

(Signed) J. P. Steen M. D.
19 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days, In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death? —
Former or usual residence Pocatello

19. PLACE OF BURIAL OR REMOVAL Mt View — DATE OF BURIAL Feb 19 1917

20. UNDERTAKER H. L. McClanahan — ADDRESS Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

29493

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 3241
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No.) General Hospital

2. FULL NAME Josh Nick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. Not Known (Month) (Day) 1871 (Year)
7. AGE about 48 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Section Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Bulgaria
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (State or Country): " "
12. MAIDEN NAME OF MOTHER: " "
13. BIRTHPLACE OF MOTHER (State or Country): " "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Pond
(Address) Pocatello Gen. Hos.
15. Filed Feb 19 1920 O. R. Steely Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 18 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1920 to Feb 18 1920
that I last saw him alive on Feb 18 1920
and that death occurred on the date stated above, at 11 32 a. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) James P. Young M. D.
2-1-1920 (Address) Pocatello Ida.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Blackfoot Idaho

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Feb 28 1920
20. UNDERTAKER: H. L. McHan ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

29494

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 32.39.

Registration District No. 84
Primary Registration District No. 7-161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 15-17 North Main St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chauncey Lester Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 15 (Day) 1919 (Year)

7. AGE ——Yrs. 6 Mos. 2 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ogden Utah

10. NAME OF FATHER: Lester J. Hill

11. BIRTHPLACE OF FATHER (State or Country): Ogden Utah

12. MAIDEN NAME OF MOTHER: Hattie Pearl Frost

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lester J. Hill
(Address) 331 Parkyane Ogden Utah

15. Filed Feb 18 1920 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-16 1920 to 2-17 1920
that I last saw h[illegible] alive on 2-17 1920
and that death occurred on the date stated above, at 5-45 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) .... Yrs. .... mos. four ds.

Contributory (Secondary)

(Duration) .... Yrs. .... mos. .... ds.

(Signed) James J. Connor M. D.
2-18-1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death —yrs. —mos. 10 days. In the State ....yrs. ....mos. 10 days

Where was disease contracted if not at place of death?

Former or usual residence Ogden Utah

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: Feb 19 1920

20. UNDERTAKER: [illegible] L. McHan — ADDRESS: POCATELLO, IDAHO

FORM V. S. No. 5-12 M. 6-15-17.

29495

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3238

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 410; N. 3rd. ave St.)

2. FULL NAME Anastasious Gonzales

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Single

6. DATE OF BIRTH. April (Month) 15 (Day) 1919 (Year)

7. AGE: — Yrs. 10 Mos. 2 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot, Idaho

10. NAME OF FATHER: Manuel Gonzales

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Mercedes Garcia

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Manuel Gonzales
(Address) 410 N. 3rd. Pocatello Ida.

15. Filed Feb. 18. 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 5th 1920 to Feb 17th 1920 that I last saw him alive on Feb 17th 1920 and that death occurred on the date stated above, at 11½ a. M.

The CAUSE OF DEATH* was as follows:
Pulmonary T.B.
(Duration) .... Yrs. .... mos. .... ds.
Contributory (Secondary): none
(Duration) .... Yrs. .... mos. .... ds.
(Signed) [illegible] M. D.
Feb 17. 1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. 4 mos. — days. In the State Life yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence: Blackfoot Idaho

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Feb 18. 1920

20. UNDERTAKER: H. L. McHaro — ADDRESS: Pocatello Ida

FORM V. S. No. 5-12 M. 6-15-17.

29496

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3237
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. .....
Primary Registration District No. .....

1. PLACE OF DEATH

County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. 323 West Lawson St.)

2. FULL NAME Infant Reddy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word)
Female	white	Single

6. DATE OF BIRTH. Feb (Month) 25 (Day) 1920 (Year)

7. AGE ——Yrs. ——Mos. 9 hours ds. IF LESS than 1 day how many 9 hrs. or ——min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pocatello Idaho

10. NAME OF FATHER Thomas L. Reddy

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Margaret McLaughlin

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas L. Reddy
(Address) 323 West Lawson St

15. Filed Feb 16, 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 15 1920 to Feby 16 1920 that I last saw h. alive on Feby 16 1920 and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
Feby 16 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State Life yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence Pocatello Idaho

19. PLACE OF BURIAL OR REMOVAL Mt View Cem Pocatello — **DATE OF BURIAL** Feb 17 1920

20. UNDERTAKER H-L-McHan — **ADDRESS** Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

29497

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 32
Registered No. 3235

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 750 N. 7 ave St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie Yakel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)
6. DATE OF BIRTH: May 8 1918 (Month) (Day) (Year)
7. AGE: ... Yrs. 9 Mos. 4 ds. IF LESS than 1 day how many .... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Kansas
10. NAME OF FATHER: Fred Yakel
11. BIRTHPLACE OF FATHER (State or Country): Russia
12. MAIDEN NAME OF MOTHER: Eva Shrader
13. BIRTHPLACE OF MOTHER (State or Country): Russia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Yakel
(Address) 750 N. 7 ave
15. Filed Feb 12 1920 O. B. Leach Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 12 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920 to Feb. 11 1920
that I last saw her alive on Feb. 10 1920
and that death occurred on the date stated above, at 5-9 M.
The CAUSE OF DEATH* was as follows:
Scarletina anginosa
(Duration) ... Yrs. 1 mos. 11 ds.
Contributory (Secondary) Facial and laryngeal paralysis
(Duration) ... Yrs. — mos. 12 ds.
(Signed) W. J. Howard M. D.
2/12/1920 (Address) Pocatello Ida.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. 6 mos. ... days. In the State — yrs. 6 mos. ... days
Where was disease contracted if not at place of death? .....
Former or usual residence Kansas.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Feb 13. 1920
20. UNDERTAKER: H. L. McHAN ADDRESS: POCATELLO, IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

29498

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31
Registered No. 3234

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1
(No. General Wash. St.)

2. FULL NAME Maud May Leighty

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: July (Month) 31 (Day) 1889 (Year)

7. AGE: 30 Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J. Wins Davis

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Francis Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Wm Leighty
(Address) 356 So. 8th Ave.

15. Filed Feb 12 1920 O. B. Greey
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920 to Feb 12 1920
that I last saw her alive on Feb 12 1920
and that death occurred on the date stated above, at 1300 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Bronchial Asthma

(Duration) 10 Yrs. mos. ds.

(Signed) J. R. Young M. D.

2/12 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. 1 mos. days. In the State 6 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Iowa

19. PLACE OF BURIAL OR REMOVAL: Dawson Iowa
DATE OF BURIAL: Feb 12 1920

20. UNDERTAKER: H. L. McHAN
ADDRESS: POCATELLO, IDAHO

29495

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31
Registered No. 3232

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 54
Primary Registration District No. 2101
(No. Lynn Bros. Has St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Ross Hartman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 11 (Day) 1920 (Year)

7. AGE: Lived 3 hours
.....Yrs. .....Mos. —ds.
IF LESS than 1 day how many 3 hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Pocatello, Idaho

10. NAME OF FATHER Thomas Edward Hartman

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Laura Monahan

13. BIRTHPLACE OF MOTHER
(State or Country) Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas E. Hartman
(Address) 405 N. Main

15. Filed Feb. 16. 1920 — P. B. Steed, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....,....M.
The CAUSE OF DEATH* was as follows:

Prematyre baby.

.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary)
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Wm Lynn M. D.
Feb 16 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Feb 17. 1920
20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

29500

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31
Registered No. 32 31

Registration District No. 84
Primary Registration District No. 2.1.61

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 341 So. main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cyrus J. Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.)
Male	white	Married

6. DATE OF BIRTH. Sept 27 (Month) (Day) 1833 (Year)

7. AGE 86 Yrs. 4 Mos. 14 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Soldier
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Isaac Taylor

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth Taylor
(Address) Bromen Okla.

15. Filed Feb 11 1920 O. T. Healy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1920 to Feb 9 1920 that I last saw h. alive on Feb 9 1920 and that death occurred on the date stated above, at 12 20 M.

The CAUSE OF DEATH* was as follows:

old age —

.....(Duration) .... Yrs..... mos. ..... ds.

Contributory (Secondary) Mitral Insufficiency

.....(Duration) .... Yrs..... mos. ..... ds.

(Signed) J. H. Lyon M. D.

2/11 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. 7 days. In the State 2 yrs. ...mos. ...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Pocatello Ida. DATE OF BURIAL Feb 11 1920

20. UNDERTAKER H. L. McClton ADDRESS Pocatello,

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

CERTIFICATE OF DEATH

29501

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 211
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. 454 So. 2nd ave. St.)

2. FULL NAME Leslie Elmond Howard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. Feb (Month) 5 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 4 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello, Idaho

10. NAME OF FATHER: ~~William D.~~ Robert M. Howard

11. BIRTHPLACE OF FATHER (State or Country): ~~Wisconsin~~ Illinois

12. MAIDEN NAME OF MOTHER: Winnie V. Howard

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert M. Howard
(Address) 454 So. 2nd ave.

15.
Filed Feb 9, 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 7th 1920 to Feb 8 1920
that I last saw him alive on Feb 7th 1920
and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:
Spasm of Glottis
(Duration) ..... Yrs. ..... mos. 3 hrs ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. H. Sprague M. D.
2-9 1920 (Address) Kane Bldg Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days, In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View — DATE OF BURIAL: Feb 9 1920

20. UNDERTAKER: H. L. McMahan — ADDRESS: Pocatello

FORM V. S. No. [redacted] 6-15-17.

CERTIFICATE OF DEATH

29502 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31
Registered No. 3227.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 340 N. Pocatello Ave. St.)

2. FULL NAME Maria Sanchez

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 2 (Month) (Day) 1919 (Year)

7. AGE: ____ Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Eulalio Sanchez

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Julia Ramiez

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Eulalio Sanchez
(Address): 340 N. Pocatello Ave. City

15. Filed Feb. 4. 1920. O B Steed Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191... to ... 191...
that I last saw h...alive on ... 191...
and that death occurred on the date stated above, at 4. a. M.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) 1 Yrs. ... mos. ... ds.

(Signed) A. D. Ferguson Comm. M. D.
2-4 1920. (Address) 352 So. 8 E.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 1 mos. — days. In the State Life ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Idaho Falls, Ida.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Feb. 5. 1920

20. UNDERTAKER: H. L. McKean ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

29503

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 3.2.2.6.

Registration District No. .....
Primary Registration District No. .....

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 12 miles E. of Pocatello up Pocatello Creek)

2. FULL NAME Agnes Helen Carlson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. Jan 21 (Month) 1908 (Day) (Year)

7. AGE: 11 Yrs. — Mos. 13 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Gus L. Carlson

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Helen M. Wallin

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gus L. Carlson
(Address) P. O. Box 1000 Pocatello

15.
Filed Feb 4 1920
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feby 3 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 3 1920 to Feby 3 1920 that I last saw h— alive on Feby. 3 1920 and that death occurred on the date stated above, at 1 — a — M.

The CAUSE OF DEATH was as follows:

Sunstroke.
Pneumonia Following
Acute pain in abdomen & Stool
(Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)
(Duration) .... Yrs. .... mos. .... ds.

(Signed) [illegible] M. D.
Feby 3 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos. 6 days. In the State 6 yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence Salt Lake City Utah

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Ut — DATE OF BURIAL: Feb 6 1920

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

29504

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 3225

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 3 miles E of Pocatello St.)
up Pocatello Creek

2. FULL NAME Labon Parks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (If Married, Widowed or Divorced, How Long?): Married

6. DATE OF BIRTH. March 14 1838
(Month) (Day) (Year)

7. AGE: 81 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): C

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Parks

11. BIRTHPLACE OF FATHER (State or Country): Conn.

12. MAIDEN NAME OF MOTHER: Beulah Messenger

13. BIRTHPLACE OF MOTHER (State or Country): Conn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Parks
(Address) 149 So. 12 ave Pocatello

15. Filed Feb 4 1920. O. R. Sieg
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 3 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1919 to Feb 3 1920
that I last saw h~~im~~ alive on Feb 2 1920
and that death occurred on the date stated above, at 11.25 A. M.

The CAUSE OF DEATH* was as follows:
Renal calculus hypertrophic chronic
Prostatitis cystitis
.....
.....
(Duration) Yrs. 4 mos. ds.
Contributory (Secondary): Myocarditis
(Duration) Yrs. 1 mos. ds.
(Signed) Asa Newton M. D.
Feb 4 1920. (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 12 yrs. mos. days. In the State 12 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Colorado

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. Pocatello — DATE OF BURIAL: Feb 5 1920

20. UNDERTAKER: L. L. McHan — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

29505

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 246
File No. 31
Registered No. 3224

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No.) St Anthony Hospital
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant of Oscar Murray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 10 (Day) 1920 (Year)

7. AGE: ~~~ Yrs. ~~~ Mos. ~~~ ds.
IF LESS than 1 day how many ~~~ hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: Oscar Murray.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Nettie Cotham

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Murray.
(Address) Fort Hall

15. Filed Mar. 10 1920
[signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1920, to Mar 10 1920, that I last saw her alive on Mch 10 1920, and that death occurred on the date stated above, at 9a M.
The CAUSE OF DEATH* was as follows: Atelectasis Pulmonum.

(Duration) 30 min. Yrs. mos. ds.
Contributory (Secondary) Premature birth-twin.
(Duration) yrs. mos. ds.

(Signed) W. W. Brothers M. D.
Mch 10 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: 3/11 1920
20. UNDERTAKER: [illegible] — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

29507

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2101
File No. 31
Registered No. 3221

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 805. So. 9 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Myers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Baby

6. DATE OF BIRTH: July (Month) 20 (Day) 1919 (Year)

7. AGE: Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello.

10. NAME OF FATHER: John L Myers

11. BIRTHPLACE OF FATHER (State or Country): Hopkinsville Ky. Feb 25 1920

12. MAIDEN NAME OF MOTHER: Mamie Deander.

13. BIRTHPLACE OF MOTHER (State or Country): Bancroft. Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John. L. Myers
(Address) 805. So 9.

15. Filed Feb 26, 1920 O. B. Street
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10 1920 to Feb 25 1920 that I last saw h... alive on Feb 25 1920, and that death occurred on the date stated above, at 1 30 P.M.

The CAUSE OF DEATH* was as follows:
cerebro-spinal meningitis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) none
(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) [illegible] M. D.
(Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View. Cemetery
DATE OF BURIAL: Feb 28 1920

20. UNDERTAKER: [illegible]
ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

29508

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 33
Primary Registration District No. 2132
File No. 108
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Paris Ida
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Elizabeth Pugmire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 15 1884
(Month) (Day) (Year)

7. AGE: 36 Yrs. ..... Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home work.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Charles.

10. NAME OF FATHER: Robert M. Pugmire

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City

12. MAIDEN NAME OF MOTHER: Carrie Pugmire

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Carrie M Pugmire
(Address) 350 Almond St S.L. City

15.
Filed 4/18 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE (51088)

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 3 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920 to April 3 1920 that I last saw her alive on April 2 1920 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Ruptured Appendicitis
Diffuse Local Peritonitis
and Abdominal Abscess.
(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. D. Sutton M. D.
4/3/20 (Address) Paris Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles Ida
DATE OF BURIAL: April 5 1920

20. UNDERTAKER: Bishop Hunt
ADDRESS: St Charles.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

29509

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake

City of Paris

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 33

Primary Registration District No. 2132

(No. ..... St.)

File No. 106

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Jane Low

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January (Month) 8 (Day) 1861 (Year)

7. AGE: 58 Yrs. 10 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Providence, Utah

10. NAME OF FATHER: Hopkin Matthews

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Margaret Morris

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David N Low

(Address) Paris, Idaho

15. Filed March 29 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1919 19..., to March 29 1920 that I last saw her alive on March 27 1920 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Breast

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Lindsay M. D.

3/29 1920 (Address) City Paris

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris

DATE OF BURIAL: 31 19...

20. UNDERTAKER: Bishop Low

ADDRESS: Paris Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13 R. L. Sutton

CERTIFICATE OF DEATH.

29510

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 107

Registered No. .....

1. PLACE OF DEATH. Bear Lake Co.

Registration District No. 33

Primary Registration District No. 3432

County of Bear Lake

City of Bloomington (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Deborah Ellen Briscoe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. 7 Sept. (Month) 10 (Day) 187[illegible] (Year)

7. AGE: 47 Yrs. ..... Mos. 6 ds. 11

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edward Haddock

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Barrett Haddock

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. V. Briscoe
(Address) Bloomington Idaho

15.
Filed 4/10/20 191.....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1920 to March 21 1920, that I last saw her alive on March 21 1920 and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Apoplexy, Hemorrhage into Cerebrum, Sept.

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) C. O. Moore M. D.

3/22 1920 (Address) Paris, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bloomington — DATE OF BURIAL: 3/24 1920

20. UNDERTAKER: Bishop Hart. — ADDRESS: Bloomington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29511

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 33

Primary Registration District No. 2132

File No. 105-

Registered No. .....

1. PLACE OF DEATH.

County of Bear Lake

City of Paris

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Carlyle Hoge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 12 (Day) 1920 (Year)

7. AGE: .....Yrs. 1 Mos. 8 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER William B. Hoge

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mary Ann Wahlen

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed 4/10/20 191.... Local Registrar

SYMS - YORK CO., PTRS. & STNS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1920 to Mar 20 1920, that I last saw h... alive on Mar 20 1920 and that death occured on the date stated above, at 2 30P M.

The CAUSE OF DEATH* was as follows:

Pneumonia L. Lg.

.....(Duration) .....Yrs. .....mos. 3 ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) C. O. Moore M. D.

3/21/1920 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris Idaho — DATE OF BURIAL: 3/22 1920

20. UNDERTAKER: Parkinson & Sons — ADDRESS: Paris

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

29512

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah

City of Wenned

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 31

Primary Registration District No.

(No. , St.)

File No. 2

Registered No. 1

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Timpso

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Mal	Indian	(Write the word.)

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE about 80 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Spokane Reservation

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Field

(Address) Wenned

15.

Filed March 17 1920

Jones E. Bihan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 17 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,

that I last saw h.... alive on ....19....,

and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Death followed an accident
He fell off a horse about November 1919

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) No doctor attended M. D.

19.... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Wenned	March 19 1920
20. UNDERTAKER John Fulcom	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

29513

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Benewah

City of Desmet

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 31

Primary Registration District No.

(No. , St.)

File No. 1

Registered No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Louis Wildshoe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Indian	Widowed

6. **DATE OF BIRTH** Yakima Reserv 1
(Month) (Day) (Year)

7. **AGE** about 85 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Washington State

10. **NAME OF FATHER** Nel Brown

11. **BIRTHPLACE OF FATHER** (State or Country) " "

12. **MAIDEN NAME OF MOTHER** " "

13. **BIRTHPLACE OF MOTHER** (State or Country) " "

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) J. B. Vallée

(Address) Desmet, Idaho

15.

Filed Feb 20 1920

Jess E. Bihan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb. 19 1920
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 19 , to 19 ,

that I last saw h alive on 19 ,

and that death occurred on the date stated above, at M.

The **CAUSE OF DEATH*** was as follows:

Pneumonia

No physician attended

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL ~~OR REMOVAL~~** Desmet — **DATE OF BURIAL** Feb. 21 1920

20. **UNDERTAKER** John Falcon — **ADDRESS**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29517
Registered No. 6

1. PLACE OF DEATH

County of Bonneville
City of Ucon
(No. ....., ... St.)

Registration District No. 31
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ayasulimas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	Indian	widowed

6. DATE OF BIRTH
Not known (Month) ..... 1 (Day) ..... (Year)

7. AGE
about 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Not known

10. NAME OF FATHER
"

11. BIRTHPLACE OF FATHER
(State or Country) "

12. MAIDEN NAME OF MOTHER
"

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rev. J. Kempler
(Address) .....

15.
Filed March 31 1920 Yves L. Bihan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Jan 15 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

No physician attended

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ucon	Jan 17 1920
20. UNDERTAKER	ADDRESS
J. Falcon	Ucon

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29519
Registered No. 10

1. PLACE OF DEATH.
County of Benewah
City of St Maries
(No. ..... St.)
Registration District No. 32
Primary Registration District No. 2059

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jack Dodson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. March 1 1920
(Month) (Day) (Year)

7. AGE ..... Yrs. — Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Murry Dodson

11. BIRTHPLACE OF FATHER
(State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Ellen Helgesen

13. BIRTHPLACE OF MOTHER
(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Murry Dodson
(Address) St Maries

15.
Filed 3/7 1920 H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 7 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1 1920, to Mar. 6 1920, that I last saw him alive on March 6 1920, and that death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:
Congenital Hemophelia of the Gastro-intestinal Mucosa.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) "Flu" in Mother - newborn baby very weak
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Kinsolving M. D.
3/7 1920 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	3/7 1920

20. UNDERTAKER	ADDRESS
H E Hunt Co	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29520
Registered No. 9

1. PLACE OF DEATH.
County of Benewah
City of St Joe
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 22
Primary Registration District No. 2049

2. FULL NAME Pentland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 7 (Day) 1919 (Year)

7. AGE: Yrs. 6 Mos. 3 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: -0-
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George H Pentland

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Mary Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George H Pentland
(Address) St Joe

15. Filed March 2 1920
H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 22 1920, to Mar 1 1920, that I last saw he alive on Jan 22 1920, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Owen D Platt M. D.

Mar 7 1920 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn
DATE OF BURIAL: 191

20. UNDERTAKER: H E Hunt Co
ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2 4 3
(No. ..... , ... St.)

File No. 29521
Registered No. 6

1. PLACE OF DEATH.
County of Benewah
City of Plummer

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lee Mark Shaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. March 15 (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. 6 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St. John, Wash

10. NAME OF FATHER: Ray L. Shaw

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Low, Fenton Mark

13. BIRTHPLACE OF MOTHER (State or Country): Red Field, Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Leo R. Marks.
(Address): Plummer, Idaho

15.
Filed Mch. 30 1920
H. L. Jaeger
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mch. (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 21 1920, to Mch 22 1920, that I last saw him alive on Mch 22 1920 and that death occured on the date stated above, at 4:00 p.m.

The CAUSE OF DEATH* was as follows:
Spanish Influenza

(Duration) No Yrs. No mos. 3 ds.
Contributory (Secondary) Pulmonary Tuberculosis

(Duration No yrs. 8 mos. ds.

Mch 22 1920 (Signed) J. W. Didier M. D.
(Address) Plummer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plummer, Idaho
DATE OF BURIAL: Mch 23 1920

20. UNDERTAKER: H. L. Jaeger
ADDRESS: Plummer Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29523
Registered No. 26

1. PLACE OF DEATH.
Registration District No. 116
Primary Registration District No. 2193
County of Power
City of American Falls (No. Bethany Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Ellen Pinkerton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Nov (Month) 9 (Day) 1919 (Year)

7. AGE
— Yrs. 5 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ...—
(b) General nature of industry, business, or establishment in which employed (or employer) ...—

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John J Pinkerton

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Mary Belle Baumister

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. J Pinkerton
(Address) Aberdeen Ida

15. Filed 3/26 20 191 M. C. Mortensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mch (Month) 26 (Day) 20 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 25 20 191, to Mch 26 20 191, that I last saw him alive on Mch 26 20 191, and that death occured on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows:
Intussusception (Intestinal)

(Duration) ... Yrs. ... mos. 2 ds.

Contributory (Secondary) ...
(Duration ... yrs. ... mos. ... ds.

(Signed) M. C. Mortensen M. D.
Mch 27 20 191 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. 1 ... days. In the State — yrs. 5 mos. 16 days
Where was disease contracted if not at place of death? Aberdeen Ida
Former or usual residence Aberdeen Ida

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Aberdeen Ida — DATE OF BURIAL: Mch 28 20 191

20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29524

Registered No. 37

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

Registration District No. 121

Primary Registration District No. 2194

(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles W. Halladay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word.): Single

6. DATE OF BIRTH. 1866-67 (Month) 1 (Day) (Year)

7. AGE: 53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Laborer Farmer & General
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) West Virginia

10. NAME OF FATHER Can't say

11. BIRTHPLACE OF FATHER (State or Country) Can't say

12. MAIDEN NAME OF MOTHER Can't say

13. BIRTHPLACE OF MOTHER (State or Country) Can't say

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) as shown by records
(Address) Blackfoot Ida

15. Filed Mar 2 1921 Mo Julia E. Pearce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 1 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1921, to Mar 1 1921, that I last saw him alive on Mar 1 1921 and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Hemorrhage, Caused by Sarcoma of Kidney
more or less Constant since
Jan 21-1921
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Sarcoma Kidney
(Duration) Can't say Yrs. ..... mos. ..... ds.

(Signed) Cyril Rogers M. D.
3/2 1921 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 9 days. In the State Idaho Insane Asylum ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Can't say
Former or usual residence Bingham Co. Idaho P.O. Aberdeen

19. PLACE OF BURIAL OR REMOVAL: To Boise Ida — DATE OF BURIAL: 1921

20. UNDERTAKER: E. J. Funk — ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2145

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29526

Registered No. 38

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kim Chang Ane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Korean

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Cant say (Month) (Day) 1 (Year)

7. AGE: 44 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Korea

10. NAME OF FATHER: Cant say

11. BIRTHPLACE OF FATHER (State or Country): Cant say

12. MAIDEN NAME OF MOTHER: Cant say

13. BIRTHPLACE OF MOTHER (State or Country): Cant say

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. A. Foor

(Address) Blackfoot, Ida

15.

Filed 3-2 1920 Mrs. Nellie E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 27 1920, to Mar 1 1920, that I last saw him alive on Feb 29 1920, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Exhaustion, + Pneumonia Lobularis

(Duration) 1 Yrs. 7 mos. — ds.

Contributory (Secondary) Excessive Opium User

(Duration) 15 yrs. ..... mos. ..... ds.

(Signed) C. A. Foor M. D.

3/2 1920 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 4 days. In the State. ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Cant say

Former or usual residence Borneo Ida Gyra

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: 3-2 1920

20. UNDERTAKER: R. S. Rossiter Acting — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 29527
Registered No. 39

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Ida. Insane Asylum St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robt Barnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Cant Say (Month) (Day) (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Cant Say

10. NAME OF FATHER Cant Say

11. BIRTHPLACE OF FATHER (State or Country) Cant Say

12. MAIDEN NAME OF MOTHER Cant Say

13. BIRTHPLACE OF MOTHER (State or Country) Cant Say

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) as per Asylum Records
(Address) Blackfoot, Ida

15.
Filed 3-3 1920 Anna Lee Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 12 1919, to Mar 3 1920, that I last saw h[illegible] alive on Mar 2 1920 and that death occured on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver

(Duration) 1 Yrs. 2 mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
3-3 1920 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
Idaho Insane Asylum
At place of death 37 yrs. 1 mos. 8 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Asylum Cemetery — DATE OF BURIAL: 3-[illegible] 1920

20. UNDERTAKER: J. J. Rossiter & Son — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 29528
Registered No. 50

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. Eagle Drive 1st St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ann Taylor
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct (Month) — (Day) 1899 (Year)

7. AGE: 30 Yrs. 5 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm Cole

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Canada

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. I HEREBY CERTIFY, That the above is true to the best of my knowledge.
(Informant) E A Hoopes
(Address) Blackfoot, Ida

15. Filed ..... 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 29 1919, to Mar 6 1920, that I last saw her alive on Mar 6 1920 and that death occured on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:
Exhaustion from Insanity
3 Insanity
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Psychosis depressed
(Duration) 4 Yrs. 5 mos. 6 ds.
(Signed) E A Hoopes M. D.
3/10 1920 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 3 mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Star, Idaho

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho — DATE OF BURIAL 191

20. UNDERTAKER: E J Peck — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 29529
Registered No. 41

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Ingraham Jones.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Feb (Month) 24 (Day) 1883 (Year)

7. AGE
37 Yrs. ..... Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Cigar Maker
(b) General nature of industry, business or establishment in which employed (or employer) Store

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER L. H. Jones

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Sarah E. Lanning

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Jones
(Address) [illegible]

15. Filed March 10 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Gun Shot Wound Left Head
Suicidal Cerebral Laceration
Instantaneous (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. J. Peck Coroner
3-8 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gem City Cemetery	March 10 1920

20. UNDERTAKER E. J. Peck — ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 29530
Registered No. 42

1. PLACE OF DEATH
County of Bingham
City of Firth Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis Henry Lyman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb. 16. 1920
(Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 3 weeks ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Henry W. Lyman.

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Viola E Lingenfelter

13. BIRTHPLACE OF MOTHER (State or Country): Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Lyman
(Address) Firth Idaho

15. Filed March 9 19 20
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-7- 1920, to 3-9- 1920, that I last saw him alive on 3-8- 1920, and that death occurred on the date stated above, at 2 3. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. W. Luck M. D.
3-9 1920 (Address) Firth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida
DATE OF BURIAL 19

20. UNDERTAKER
ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 29531
Registered No. 43

1. **PLACE OF DEATH**

County of Bingham
City of Blackfoot (No. 20 South Shelley Ave)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Jasper Willard Conkle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. **DATE OF BIRTH** Sept. (Month) 13 (Day) 1861 (Year)

7. **AGE** 58 Yrs. 5 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Penn.

10. **NAME OF FATHER** Henry Conkle

11. **BIRTHPLACE OF FATHER** (State or Country) Penn.

12. **MAIDEN NAME OF MOTHER** Mary Jane Whumm

13. **BIRTHPLACE OF MOTHER** (State or Country) Penn.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Elba E. Conkle
(Address) Blackfoot, Idaho

15. Filed March 19 ..... Mrs Nalie E. Watkins
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** March (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ March 9/1920 to ..... 19.....
that I last saw h~~im~~ alive on March 9/20 1920,
and that death occurred on the date stated above, at 8:40 A.M.
The CAUSE OF DEATH* was as follows: Mitral regurgitation & Cirrhosis of Liver
(Duration) not known yrs. / known mos. ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. O. Hamptain M. D.
3/11 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grant Cem Cemetery	March 13 1920
20. UNDERTAKER	**ADDRESS**
E. J. Peck	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 1007

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29532

Registered No. 44

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. Blackfoot Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. February (Month) 3 (Day) 1850 (Year)

7. AGE: 70 Yrs. 1 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Morton Johnson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Belo Ball

(Address) Blackfoot.

15. Filed ..... 191 ..... Mrs Nellie E. Wood Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1920, to March 11 1920, that I last saw h.m alive on March 11 1920, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Renal Calculus

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) F. W. Mutchell M. D.

3/11 1920 (Address) Blackfoot, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lone City cemetery — DATE OF BURIAL: Mar 13 1920

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. 2nd ... St.)

File No. 29533
Registered No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham
City of Blackfoot

(If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 3 (Month) 12 (Day) 1720 (Year)

7. AGE: 39 Yrs. 9 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Can't say

11. BIRTHPLACE OF FATHER (State or Country): Can't say

12. MAIDEN NAME OF MOTHER: Can't say

13. BIRTHPLACE OF MOTHER (State or Country): Can't say

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Laura E. Rice
(Address) Bellevue, Ida

15.
Filed ..... 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1918, to 3/12 1920, that I last saw him alive on 3/12 1920 and that death occured on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Septic Pneumonia

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) Senile Gangrene
(Duration) Supposed Years ..... mos. ..... ds.

(Signed) C. A. Brown M. D.
3/13 1920 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
State Insane Asylum
At place of death 1 yrs. 10 mos 12 days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? Can't say
Former or usual residence Bellevue, Ida 5 Years

19. PLACE OF BURIAL OR REMOVAL: Bellevue Idaho | DATE OF BURIAL ..... 191 .....
UNDERTAKER: E. J. Peck | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back

City of Blackfoot. (No. ....., ... St.) Registered No. 46

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Henry Bingham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April (Month) 13 (Day) 1882 (Year)

7. AGE: 37 Yrs. 11 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Huntsville Utah

10. NAME OF FATHER: Erastus Perry Bingham

11. BIRTHPLACE OF FATHER (State or Country): Lahaype Illinois

12. MAIDEN NAME OF MOTHER: Emiline Clarissa Allen

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W W Bingham
(Address) Riverside Utah

15. Filed 3-14 1920 Mrs Nalen E. Pate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1920, to March 13 1920, that I last saw h[illegible] alive on March 13 1920, and that death occurred on the date stated above, at 4 45 A.M. The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) F. M. Mitchell M. D.

3/13 1920 (Address) F. M. Mitchell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas F Riverside Cem. DATE OF BURIAL: Mar. 15 1920

20. UNDERTAKER: Ed L. Egli ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29535
Registered No. 47

1. PLACE OF DEATH.
Registration District No. 121
Primary Registration District No. 1007
County of Bingham
City of Blackfoot, Idaho No. 210 Broadway St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lester Bullcane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	Single

6. DATE OF BIRTH.
March 15 1920
(Month) (Day) (Year)

7. AGE
.....Yrs.....Mos.....ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho.

10. NAME OF FATHER E. O. Bullcane

11. BIRTHPLACE OF FATHER
(State or Country) Logan Utah.

12. MAIDEN NAME OF MOTHER Maggie Skinner

13. BIRTHPLACE OF MOTHER
(State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E O Bullcane
(Address) Blackfoot Idaho

15.
Filed .....191.....
Mrs Nalen E. Paben
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 15 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1920, to March 15 1920, that I last saw him alive on .....191....., and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Still born.

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration .....yrs.....mos.....ds.

(Signed) H. J. Simmons M. D.
3/13 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fairview Cemetery	3-15 1920
20. UNDERTAKER	ADDRESS
E J Peck	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. Ida-Jerome Co. Line St.)

File No. 29536
Registered No. 47

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot.
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph F. Harrison

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 22 (Day) 1861 (Year)

7. AGE: 58 Yrs. 3 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Has been Guard at
(b) General nature of industry, business, or establishment in which employed (or employer): Idaho State Penitentiary

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: Can't say

11. BIRTHPLACE OF FATHER (State or Country): Can't say

12. MAIDEN NAME OF MOTHER: Can't say

13. BIRTHPLACE OF MOTHER (State or Country): Can't say

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Records
(Address) Idaho Penitentiary

15.
Filed ..... 191...
M. Hahn E. Parker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
(Month) Mar (Day) 15 (Year) 1920

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1920, to Mar 15 1920, that I last saw h alive on Mar 15 1920 and that death occured on the date stated above, at 5.50 P.M.

The CAUSE OF DEATH* was as follows:
General Paralysis
(Duration) ..... Yrs. 5 mos. ..... ds.
Contributory (Secondary) Cystitis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. H. Hoyt M. D.
3/16 1920 (Address) Idaho Penitentiary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs. 1 mos 1 days
Where was disease contracted if not at place of death? .....
Former or usual residence Albion, Idaho

19. PLACE OF BURIAL OR REMOVAL: Burley Idaho
DATE OF BURIAL: ..... 191...
UNDERTAKER: E. F. Peck
ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 Rev. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29537

Registered No. 49

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No.) Idaho Insane Asylum (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Carter Doss

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 26 (Day) 1875 (Year)

7. AGE: 44 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Did not know

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Donovan R. La Reed M.S.
(Address) Idaho Insane Asylum

15.
Filed ..... 191 ..... Mrs Nalie E. Pabst
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October-10 1919, to March-16- 1920,
that I last saw h.sm alive on March-16- 1920,
and that death occured on the date stated above, at 10.20 P.M.

The CAUSE OF DEATH* was as follows:
Uremia - from Acute Nephritis

3/12/19 (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Psycosis excited

..... (Duration ..... yrs. ..... mos. ..... ds.

Per (Signed) Clayton A. Hoover M. D.
OR, 19... (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 5 mos. 6 days. In the State ..... yrs. 9 mos. 6 days
Where was disease contracted if not at place of death?
Former or usual residence Atwood, Illinois

19. PLACE OF BURIAL OR REMOVAL: Grove Cemetery — DATE OF BURIAL: 3-18-1920

20. UNDERTAKER: E. Peck — ADDRESS: Blackfoot Ida.

SYMS - YORK CO., PTRS. & SDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 1007

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29538

Registered No. 50

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot (Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helena Carrie Jeune

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 10 (Day) 1919 (Year)

7. AGE: ....Yrs. 10 Mos. ....ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Chas E. Jeune

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Bertha Baird.

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) ....

(Address) b. C. Diver, Blackfoot

15.

Filed ....191.... Wm Hale [illegible]
Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1920 to March 26 1920, that I last saw h[illegible] alive on March 26 1920, and that death occured on the date stated above, at 2:55 p M.

The CAUSE OF DEATH* was as follows:

Pneumonia

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) ....

....(Duration) ....yrs. ....mos. ....ds.

(Signed) W. H. [illegible] M. D.

3/26 1920 (Address) Blackfoot Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Fem cty Cemetery — DATE OF BURIAL ....191....

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 1007

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29539

Registered No. 3-1

1. **PLACE OF DEATH**

County of Bingham

City of Blackfoot

(No. Park & Broadway St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Margaret Rosena Buttars

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married (Write the word.)

6. **DATE OF BIRTH** April (Month) 12 (Day) 1902 (Year)

7. **AGE** 17 Yrs. 11 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Iowa Utah

10. **NAME OF FATHER** J. W. Skinner

11. **BIRTHPLACE OF FATHER** (State or Country) Utah Blair

12. **MAIDEN NAME OF MOTHER** Sarah Blair

13. **BIRTHPLACE OF MOTHER** (State or Country) Iowa

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) E O Buttars

(Address) Blackfoot Idaho

15.

Filed ..... 19 .....

Mrs Nalis E. Fabis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** March (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1920, to March 23 1920

that I last saw her alive on March 23 1920

and that death occurred on the date stated above, at 10 45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.

3/25 1920. (Address) Blackfoot Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Gem Cemetery

DATE OF BURIAL 3-26-1920

20. **UNDERTAKER** E. J. Peck

ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2197.
(No. ..... St.)

File No. 29540
Registered No. 52

1. PLACE OF DEATH

County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary May Cole Hutchison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 2 (Month) (Day) 1897 (Year)

7. AGE: 22 Yrs. 10 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Cole

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Sarah Cole

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mary May Hutchison
(Address):

15. Filed 3-30 1920 Nels E. Peterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 30 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 27 1920, to March 30 1920, that I last saw her alive on March 30 1920, and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) F. M. Mitchell M. D.
3/30 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ima Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: E J Peck. — ADDRESS: Blackfoot Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 131

Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29541

Registered No. 53

1. PLACE OF DEATH

County of Bingham

City of Moreland

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosco Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: January (Month) 24 (Day) 1908 (Year)

7. AGE: 12 Yrs. 2 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Floyd Co. Kentucky

10. NAME OF FATHER: R. L. Jones

11. BIRTHPLACE OF FATHER (State or Country): Floyd Co. Kentucky

12. MAIDEN NAME OF MOTHER: Emily Mullens.

13. BIRTHPLACE OF MOTHER (State or Country): Virginia State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. L. Jones

(Address) Idaho

15. Filed 4- 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1920, to March 1920, that I last saw h.im alive on March 29 1920, and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — Yrs. — mos. 9 ds.

Contributory (Secondary) Influenza

(Duration) — yrs. — mos. 2 ds.

(Signed) A. H. McFarland M.D.

4/1 1920 (Address) Blackfoot Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland — DATE OF BURIAL ..... 19.....

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2343
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonner
City of Coeur d'Alene Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2155
(No. ....., ... St.)

2. FULL NAME August H. Ohme

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word) Widowed

6. DATE OF BIRTH. Nov. 11 1869
(Month) (Day) (Year)

7. AGE 51 Yrs. 4 Mos. 19 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Milwaukee Wisc.

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Floyd Wendle
(Address) Sandpoint Ida.

15. Filed April 5 1920. FLOYD G. WENDLE Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 1 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 22 1920 to ..... 191..
that I last saw him alive on Mch 22 1920
and that death occurred on the date stated above, at 7.30 a. M.

The CAUSE OF DEATH* was as follows:
Result of Spinal Injury
.....
.....
.....(Duration) 15 Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration)..... Yrs..... mos. ..... ds.

(Signed) Floyd Wendle M. D.
4-7 1920 (Address) Sandpoint Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kootenai Idaho — **DATE OF BURIAL** 4/2 1920

20. UNDERTAKER — **ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29544
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2165
(No. ....., ... St.)

2. FULL NAME Helen Lois Stellflue

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. March (Month) Seventh (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 7 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sandpoint, Ida.

10. NAME OF FATHER: Floyd E Stellflue

11. BIRTHPLACE OF FATHER (State or Country): Gale, Wisc

12. MAIDEN NAME OF MOTHER: Alice Turnbull

13. BIRTHPLACE OF MOTHER (State or Country): Neilsville, Wisc.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Floyd Ellendale
(Address): Sandpoint, Ida.

15. Filed April 8 1920. FLOYD G. WENDLE Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-7- 1920 to 3-14 1920
that I last saw her alive on 3-14 1920
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
.....
.....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Floyd Ellendale M. D.
3-15 1920 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: 3/15 1920

20. UNDERTAKER — ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2135
File No. 29545
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. , St.)
If death occurs away from usual residence, give facts called for under special information. Kootenai

2. FULL NAME Charlotte Annie Bonner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 3 (Day) 1851 (Year)

7. AGE: 69 Yrs. — Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Stephen Brownigg

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Catherine Doyle

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Bonner
(Address) Kootenai Ida.

15. Filed April 8 1920
FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1919, to Mar 31 1920, that I last saw her alive on Mar 27 1920, and that death occurred on the date stated above, at 7-30 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. 4 mos. ..... ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) Floyd Bellows M.D.
4-1 1920 (Address) Sandpoint.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Missoula Mont. DATE OF BURIAL: 4/7 1920

20. UNDERTAKER: E M Brower ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2155
(No. ..... St.)

File No. 29547
Registered No. .....

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fang Kee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook.
(b) General nature of industry, business or establishment in which employed (or employer): Restaurant

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed Brown
(Address) Sandpoint

15. Filed April 8 1920 FLOYD G. WENDLE Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 14, 1920, to Jan 23 1920, that I last saw h.. alive on Jan 23 1920, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis

(Duration) Several Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Cardiac Insufficiency
(Duration) 3 to 5 yrs. ..... mos. ..... ds.

(Signed) C. P. Starkweather M. D.
1/19 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jan 24 Sandpoint DATE OF BURIAL: Jan 24 1920

20. UNDERTAKER: Ed Brown ADDRESS: S.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

29548 Stark

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2150
File No. 2954
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert L. Bellamy.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Dec (Month) 13 (Day) 1840 (Year)

7. AGE: 79 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business or establishment in which employed (or employer): Saw mill Ret.

9. BIRTHPLACE (State or Country): Mass.

10. NAME OF FATHER: A Bellamy

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Clara White

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E E Bellamy
(Address) Hope Ida

15. Filed Jan 9 1920 FLOYD G. WENDLE Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 12 1920 to Jan 23 1920 that I last saw him alive on Jan 22 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Infected Prostates.

(Duration) several Yrs. ..... mos. ..... ds.

Contributory (Secondary) Apoplexy

(Duration) ..... yrs. several mos. ..... ds.

(Signed) C. F. Staddon M. D.

3/19 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Kootenai

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: Jan 25 1920

20. UNDERTAKER: Ellis Power — ADDRESS: Sp

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Boise

City of Idaho

Registration District No. 81

Primary Registration District No. 2158

(No. ..... St.)

File No. 29553

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Earl Welter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July 16 (Month) (Day) 1918 (Year)

7. AGE: 1 Yrs. 7 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... at home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Floyd Welter

11. BIRTHPLACE OF FATHER (State or Country) Ontario Canada

12. MAIDEN NAME OF MOTHER Laura Clemence

13. BIRTHPLACE OF MOTHER (State or Country) S. Dak

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Floyd Welter

(Address) Idaho

15. Filed 3-12 1920 N R Williams Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 - 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920, to Mar 3 1920, that I last saw h[illegible] alive on Mar 3 1920, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Doctor pneumonia

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) N R Williams M. D.

19.... (Address) Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho — DATE OF BURIAL: 3-4 1920

20. UNDERTAKER [illegible] — ADDRESS [illegible]

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29554
Registered No. 17

1. PLACE OF DEATH
County of Bonner
City of Priest River Ida. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 85
Primary Registration District No. 2180

2. FULL NAME Carl Lester Ritchey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mch
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Sgle (Write the word.)

6. DATE OF BIRTH: March 21 1917 (Month) (Day) (Year)

7. AGE: — Yrs. 11 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter Ritchey

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Edna Erickson

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Walter Ritchey
(Address) Priest River Idaho

15. Filed March 30 1920 — C P Goff — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 15 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1920, to March 15 1920, that I last saw him alive on March 15 1920, and that death occurred on the date stated above, at 9.40 A.M.
The CAUSE OF DEATH* was as follows:
Infantile Convultions
(Infatile convultions.)
(Duration) — Yrs. — mos. 1 ds.
Contributory (Secondary) .....
(Duration) — yrs. — mos. — ds.
(Signed) C P Goff M. D.
Mar 16 1920 (Address) Priest River, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest River — DATE OF BURIAL: March 19 20

20. UNDERTAKER: Jas Ritchey Grandfather — ADDRESS: Priest River Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1 29555
Registered No. 15

1. PLACE OF DEATH

Registration District No. 85
Primary Registration District No. 2 185

County of Bonner
City of Priest River Ida. (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick O'Golder,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 12 (Day) 1887 (Year)

7. AGE: 32 Yrs. 2 Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Log scaler Government service
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Morocco Africa,

10. NAME OF FATHER: John O'Golder

11. BIRTHPLACE OF FATHER (State or Country): Mont.

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Patrick O'Golder
(Address) Priest River Idaho.

15. Filed March 30 1920 C. P. Getzloff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1920, to March 5 1920 that I last saw him alive on March 2 1920, and that death occurred on the date stated above, at 10.37 A.M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ---- Yrs. ---- mos. 6 ds.
Contributory (Secondary) Spanish Influenza,
(Duration) ---- yrs. ---- mos. 6 ds.

(Signed) C. P. Getzloff M. D.
Mar. 5 1920 (Address) Priest River

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
Priest River	
20. UNDERTAKER Wm Davis	ADDRESS Newport

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner

Registration District No. 35

Primary Registration District No. 2185

File No. 29556

City of Priest River, Ida (No. ....., ... St.)

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene Patrick Murray.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July (Month) 21 (Day) 1901 (Year)

7. AGE: 18 Yrs. 7 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer on woods
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: M.E.Murray

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Anna V. Murray.

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M E Murray
(Address) Priest River, Ida

15. Filed Mar 30 1920 C P Gotshall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March, (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 1920, to Marc 11 1920, that I last saw him alive on Marc 10 1920, and that death occurred on the date stated above, at 8.30 A. M.

The CAUSE OF DEATH* was as follows:

Abcess of Lung

(Duration) — Yrs. — mos. 8 ds.

Contributory (Secondary) Spanish Influenza

(Duration) — yrs. — mos. — ds.

(Signed) C. P. Gotshall M. D.

Mar 12 1920 (Address) Priest River Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Priest River Ida	Mar 15 1920

20. UNDERTAKER	ADDRESS
Wm Dean	Newport. Wn.

BYRNE-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29557

Registered No. 47

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 2 1 1 0

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willard Garvey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April 14 1836
(Month) (Day) (Year)

7. AGE: 84 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Shenectady N.Y.

10. NAME OF FATHER: Isaac Nash

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Sinthan Farrer

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lewis Barker
(Address) Casper Wyoming

15. Filed Mar 23 1920 W. Jeffries Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 22, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 13 1920 to Mar 22 1920 that I last saw h[illegible] alive on Mar 21 1920 and that death occurred on the date stated above, at 7:30 P.M.,

The CAUSE OF DEATH* was as follows:

Acute Cystitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. M. Shupe M. D.

3/22 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Casper Wyo. DATE OF BURIAL: Mar 1920

20. UNDERTAKER: [illegible] ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29559
Registered No. .....

1. PLACE OF DEATH.
County of Custer. Butte
City of Darlington
(No. ....., ... St.)
Registration District No 59
Primary Registration District No 12 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lottie Mae Magee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH. Feb (Month) 17 (Day) 1886 (Year)

7. AGE: 34 Yrs. ..... Mos. 20 ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kerney, Nebr.

10. NAME OF FATHER William Lee

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Eliza Browngbeck

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. D. Magee
(Address) Darlington, Idaho

15. Filed 3/9 191 12 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7 1920, to ..... 191..., that I last saw h[illegible] alive on Mar 7 1920, and that death occured on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia,
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary)
(Duration ..... Yrs. ..... mos. ..... ds.

3/9 (Signed) W. H. Tyner M. D.
19 12 (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burial Ida. | DATE OF BURIAL: 3/12 1912

20. UNDERTAKER: A. & E. P. McHan | ADDRESS: Ass Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 29560
Registered No. 55

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David B Myers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): married

6. DATE OF BIRTH: Oct (Month) 10 (Day) 1857 (Year)

7. AGE: 62 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: William Myers

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Maggie Barrick

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs D.B. Myers
(Address) Caldwell Idaho

15.
Filed 4-8-1920
John S. Meyers
Local Registrar

BYNES - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1920; to April 7 1920, that I last saw him alive on April 6 1920, and that death occured on the date stated above, at 9-30 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) Yrs. not known mos. ds.
Contributory (Secondary) Hemorrhage of lungs
(Duration) yrs. mos. 10 ds.
(Signed) J M Allen M. D.
4/6 1920 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 4-8 1920

20. UNDERTAKER: C E Buckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Ada

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 1005

(No. ..... St.)

File No. 29561

Registered No. 54

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James A Vick

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH

June 24 1854
(Month) (Day) (Year)

7. AGE

66 Yrs. 2 Mos. 6 ds.

IF LESS than 1 day
how many ..... hrs.
or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER A. D. Vick

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Reece

13. BIRTHPLACE OF MOTHER (State or Country) Maryland

14. THE ABOVE IS TRUE TO THE BEST OF ~~MY~~ KNOWLEDGE

(Informant) [redacted]

(Address) Chas Gritton

15.

Filed 3-31- 1920 John S. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 30 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 11 1920 to March 30 1920

that I last saw h.. alive on March 28 1920

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

..... (Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

3/30 1920 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER CASE FURNITURE CO.	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

County of Canyon

City of Caldwell (No. ....., ... St.)

File No. 29569

Registered No. 593

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Norman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): married

6. DATE OF BIRTH. Sept (Month) 18 (Day) 1836 (Year)

7. AGE: 83 Yrs. 5 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.. Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York.

10. NAME OF FATHER Jim. Norman

11. BIRTHPLACE OF FATHER (State or Country) New York.

12. MAIDEN NAME OF MOTHER Don't know

13. BIRTHPLACE OF MOTHER (State or Country) London England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas E Norman
(Address) Parma R.D #1

15. Filed 3-30- 1920 John S. Meyers Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1920, to Mar 26 1920, that I last saw h'm alive on Mar 26 1920 and that death occured on the date stated above, at 11-15 P.M.

The CAUSE OF DEATH* was as follows:
Cardiac Asthma
Lobar Pneumonia,

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) H D Forrer M. D.

3/29 1920 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	3-31 1920

20. UNDERTAKER	ADDRESS
C. E. Peckham	Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2002
(No. ..... St.)

File No. 29563
Registered No. 52

1. PLACE OF DEATH

County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Alexanderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	married

6. DATE OF BIRTH: Jan (Month) 25 (Day) 1873 (Year)

7. AGE: 47 Yrs. 2 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER P. A. Johanson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Johanna

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. M. Alexanderson
(Address) R. 2 Caldwell Idaho

15. Filed 3-29- 1920 John L. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1920, to March 28 1920, that I last saw h.... alive on March 26 1920; and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Carcinoma of oesophagus

.....(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Lee M. D.

3/29 1920 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 19....
20. UNDERTAKER CASE FURNITURE CO. CALDWELL, IDAHO	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 1005

File No. 29564

Registered No. 51

County of Canyon

City of Caldwell

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry L. Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. August 13 1860
(Month) (Day) (Year)

7. AGE: 59 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: clerk
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dlc

10. NAME OF FATHER: Sean Evans

11. BIRTHPLACE OF FATHER (State or Country): Dont Know Va.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Dlc

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J H Evans
(Address) Caldwell Idaho

15. Filed 3-23- 1920 John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 21 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 21 1920 to Mar 21 1920, that I last saw her alive on March 21 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. Few hours ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Kelly M. D.

3-21 1920 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 3-24 1920

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

EVANS - HOWE CO., PTRS. & ENGS. 24652

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ..... St.)

File No. 29565
Registered No. 32

1. PLACE OF DEATH.
County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fidelio Patton Ball

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): married

6. DATE OF BIRTH. Nov. (Month) 16 (Day) 1830 (Year)

7. AGE ..... Yrs. 7 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. J. Ball Jr.
(Address) Caldwell, Ida.

15. Filed 3-23- 1920 John L. Myers Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 20 1920 to Mar 21 1920 that I last saw him alive on Mar. 2d 1920 and that death occured on the date stated above, at 8:45 P. M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency due to Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. H. Taylor M. D.
3-22 1920 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 3-23 1920

20. UNDERTAKER: C. O. Peckham — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 29566
Registered No. 49

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Simon (Simon) Crosier

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH. April 5 (Month) (Day) 1857 (Year)

7. AGE: 62 Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Ace Crosier

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Holland

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Floyd Meyer
(Address) Marsing Ida #3

15. Filed 3-15- 1920
John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 14 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14 1920, to Mar. 14 1920, that I last saw h.im alive on March 14 1920, and that death occured on the date stated above, at 9 45 P.M.

The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) — Yrs. — mos. 3 hrs. da.
Contributory (Secondary) High blood pressure
(Duration Several yrs. mos. ds.
(Signed) P. J. Young M. D.
3-15 1920 (Address) Caldwell

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlen Town — DATE OF BURIAL: 3-16 1920

20. UNDERTAKER: E. A. Beckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2003
(No. ..... , ... St.)

File No. 29567
Registered No. 48

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Wellington Eames

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 24 (Day) 1862 (Year)

7. AGE: 38 Yrs. 0 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: E. W. Eames

11. BIRTHPLACE OF FATHER (State or Country): Illinois Wisconsin

12. MAIDEN NAME OF MOTHER: Francis Brown

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John M. Eames
(Address) Caldwell Idaho

15. Filed 3-14- 1920
John D. Mayes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 3 1920, to Mar 12 1920, that I last saw him alive on Mar 12 1920, and that death occured on the date stated above, at [redacted] P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. M. Kelley M. D.
3-12 1920 (Address) Caldwell Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Ridge — DATE OF BURIAL: Mch 14 1920

20. UNDERTAKER: C. C. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 9

County of Canyon

Primary Registration District No. 2007

File No. 29568

City of Parma

(No. ....., ... St.)

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Harris

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
F	W	S

6. DATE OF BIRTH

Apr 7 (Month) 7 (Day) 1901 (Year)

7. AGE

18 yrs. 11 mos. 19 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ore

10. NAME OF FATHER Thomas Harris

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Jane Moffett

13. BIRTHPLACE OF MOTHER (State or Country) Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lizzie Harris

(Address) Parma Ida.

15. Filed March 28 1920 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

March 25 1920

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 27 1920, to Mar. 23 1920 that I last saw her alive on Mar 23 1920 and that death occurred on the date stated above, at 30 M.

The CAUSE OF DEATH* was as follows:

Pulmonary & abdominal tuberculosis

(Duration) about yrs. 6 mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Nuland M. D.

19..... (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Parma | DATE OF BURIAL March 28 1920

20. UNDERTAKER Peckham Co | ADDRESS Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 29569
Registered No. ....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ...., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH.
Oct. (Month) 10 (Day) 1829 (Year)

7. AGE
91 Yrs. 5 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ....
(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

9. BIRTHPLACE
(State or Country) Penn.

10. NAME OF FATHER
Masonheimer,

11. BIRTHPLACE OF FATHER
(State or Country) Maryland.

12. MAIDEN NAME OF MOTHER
Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) B.L. Johnson
(Address) Nampa

15.
Filed 4/3/ 20 191 Pearle Dodds Local Registrar
F.K. Robinson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-31 1920, to 4-3 1920, that I last saw her alive on 4-3 1920 and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Spotted fever Rocky Mountain fever?

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Senility
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F.K. Robinson M. D.
4/6 1920 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days
In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem;
DATE OF BURIAL: 4/4/20 191

20. UNDERTAKER: F.K. Robinson
ADDRESS: Nampa Ida.

of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOOKS. 2488

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 2937
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey Vandepool
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~ (Write the word.)

6. DATE OF BIRTH: June (Month) 29 (Day) 1903 (Year)

7. AGE: 16 Yrs. 8 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ore

10. NAME OF FATHER: W. C. Vandepool

11. BIRTHPLACE OF FATHER (State or Country): Ore

12. MAIDEN NAME OF MOTHER: Edith Sawyer

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Vandepool
(Address) Nampa

15. Filed March 24 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-24 1920, to 3-24 1920 that I last saw him alive on 3-24 1920 and that death occurred on the date stated above, at 5:20 M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) yrs. mos. 3 ds.
Contributory (Secondary) Gunshot, debilitated.
(Duration) yrs. mos. ds.

(Signed) H. C. Robinson M. D.
3-26 1920 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glen Dell Cem. DATE OF BURIAL 19

20. UNDERTAKER: H. C. Robinson ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Nampa,
(No. ....., ... St.)
Registration District No. 7
Primary Registration District No. 1806
File No. 29571
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hazel M Carpenter.

PERSONAL AND STATISTICAL PARTICULARS.

3. SEX: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.
6. DATE OF BIRTH: Nov'. 21st. 1918. (Month) (Day) (Year)
7. AGE: 1 Yrs. 5 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho.
10. NAME OF FATHER: M.W.Carpenter.
11. BIRTHPLACE OF FATHER (State or Country): Nebraska.
12. MAIDEN NAME OF MOTHER: Eliose Mattson.
13. BIRTHPLACE OF MOTHER (State or Country): Nebraska.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M.W.Carpenter.
(Address) Nampa Idaho.
15. Filed March 26 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 26 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1919 to March 26 1920, that I last saw her alive on March 26 1920 and that death occured on the date stated above, at 1.20 M.
The CAUSE OF DEATH* was as follows:
Paralysis
(Duration) ..... Yrs. ..... mos. 24 ds.
Contributory (Secondary) Status Lymphaticus
(Duration) Nov 21st 1 yrs. 5 mos. 4 ds.
(Signed) W. L. Pondexter M. Therapist
3-26 1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 3/26 1920
20. UNDERTAKER: F.K.Robinson. ADDRESS: Nampa Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & STNRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 1056

File No. 29572

County of Canyon

City of Nampa (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Horace G.Heilig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Sep. 20 ~~1920~~ 1842 (Month) (Day) (Year)

7. AGE: 77 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer (retired)
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Vir.

10. NAME OF FATHER: Daniel Heilig

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Julia Wigley

13. BIRTHPLACE OF MOTHER (State or Country): Vir.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H M Heilig
(Address) Nampa Ida

15. Filed March 27 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 16th. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 16 1920, to ..... 191..., that I last saw him alive on Mar. 16th. 1920, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Paralysis. Apoplectic

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J D Mulvey M. D.

3/17 1920 (Address) Nampa, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 3/18/20

20. UNDERTAKER: Fred K Robinson ADDRESS: Nampa

Should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

File No. 29573

County of Owyhee

~~City~~ Village of Murphy

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Domingo Berriatua

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Spanish	Married

6. DATE OF BIRTH.

1873 (Month) (Day) 1 (Year)

7. AGE

47 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Sheep Herder

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Spain

10. NAME OF FATHER No further statistics

11. BIRTHPLACE OF FATHER (State or Country) obtainable

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred K. Robinson

(Address) Nampa Ida

15.

Filed March 15 1920 Pearle Dodds Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 14th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1919, to March 14, 1920, that I last saw h[im] alive on March 14, 1920, and that death occured on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

~~Acute Lobar Pneumonia~~

General adenitis of undetermined origin.

(Duration) 1 Yrs. 5 mos. 2 ds.

Contributory (Secondary) General adenitis of unknown origin. Acute Lobar Pneumonia

(Duration 0 yrs. 0 mos. 2 ds.

(Signed) Wm. A. A. Kelly M. D.

19 ..... (Address) Nampa Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nampa (Catholic Cem.)

DATE OF BURIAL: 3-16-20

20. UNDERTAKER: Fred K. Robinson

ADDRESS: Nampa Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29574

Registration District No. 7
Primary Registration District No. 2006
(No. ....., ... St.)
Registered No. .....

1. PLACE OF DEATH.
County of Canon
City of Kuna

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jeanette Lowe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. January sixteen (Month) (Day) 1913 (Year)

7. AGE: Seven Yrs. one Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER William H. Lowe

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Anna H. Klugkust

13. BIRTHPLACE OF MOTHER (State or Country) Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm H. Lowe
(Address) Kuna R D I

15.
Filed March 13 1920 Earle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8-22 1920, to — 191..., that I last saw her alive on 2-22 1920, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows: General Status Lymphaticus - with Chronic Adenitis Due to Long Standing condition with marked Involvement of Cervical Glands

Duration 5 Yrs. mos. 2 ds.

Contributory (Secondary) Cervical Vertebra

Duration yrs. mos. ds.

(Signed) F. J. Coleman M. D.

3-9 1920 (Address) Kuna Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kuna Lawn Cem. DATE OF BURIAL: 3-11 1920

20. UNDERTAKER: Crowe ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

8V168 - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 1920 68 S.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 29575
Registered No. ____

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. 310 - 9th Ave N St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas M Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 3 (Day) 1852 (Year)

7. AGE: 68 Yrs. ____ Mos. 28 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Merritt Legore
(Address) Nampa Ida

15. Filed March 13 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920, to Mar 11 1920, that I last saw h~~im~~ alive on Mar 11 1920 and that death occured on the date stated above, at 7 30 AM.

The CAUSE OF DEATH* was as follows:
Chronic heart disease
(Mitral regurgitation)
Lobar Pneumonia
(Duration) Many yrs. ____ mos. ____ ds.
Contributory (Secondary) Arteriosclerosis
(Duration) Many yrs. ____ mos. ____ ds.
(Signed) Leo M Chilton M. D.
19____ (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs ____ mos ____ days. In the State ____ yrs ____ mos ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: K. L. Cemetery — DATE OF BURIAL: 3-13 1920

20. UNDERTAKER: Fred R Robertson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29576
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. 10th Ave & 5th St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1006

2. FULL NAME Thomas B. Gillasby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Feb (Month) 8 (Day) 1847 (Year)
7. AGE: 73 Yrs. 1 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)..... (Retired)
9. BIRTHPLACE (State or Country) Canada
10. NAME OF FATHER —
11. BIRTHPLACE OF FATHER (State or Country) Canada
12. MAIDEN NAME OF MOTHER —
13. BIRTHPLACE OF MOTHER (State or Country) —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Ray Gillasby
(Address) Nampa Ida
15. Filed Mar. 29, 1920 Pearle Dodds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3/21 1920, to 3/28 1920, that I last saw him alive on 3/28 1920, and that death occured on the date stated above, at 11:30 P.M.
The CAUSE OF DEATH* was as follows:
Senility
..... (Duration) — Yrs. — mos. 14 ds.
Contributory (Secondary) .....
..... (Duration) — yrs. — mos. — ds.
(Signed) [illegible] M. D.
3/29, 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: K. of P. Cemetery — DATE OF BURIAL: 3/29 1920
20. UNDERTAKER: Fred C. Robinson — ADDRESS: Nampa

Mc Cleland

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 29577
Registered No. .....

1. PLACE OF DEATH.

County of Canyon
City of Nampa
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matthew V. Berger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.: Jan. (Month) 26 (Day) 1856 (Year)

7. AGE: 64 Yrs. 2 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business, or establishment in which employed (or employer): Germany

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ********

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: *********

13. BIRTHPLACE OF MOTHER (State or Country): *********

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Berger,
(Address) Nampa Idaho

15. Filed April 6 1920 Pearle Dodds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4/4/1920 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6. 1920 191** to April 4, 1920 191, that I last saw him alive on April 4, 1920 191, and that death occured on the date stated above, at 7:20 M.

The CAUSE OF DEATH* was as follows:
Melastatic Carcinoma, Right kidne
& Base of Brain.

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Carcinoma of prostate Gland.

(Duration 1 yrs. mos. ds.

(Signed) Geo. O. A. Kellogg M. D.

19 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah. DATE OF BURIAL: 4/7/20 191-

20. UNDERTAKER: F. H. Robinson ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1886
File No. 29578
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna May Cox.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct! (Month) 14. (Day) 1884 (Year)

7. AGE: 35 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife,
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER ---- Devore

11. BIRTHPLACE OF FATHER (State or Country) Penn.

12. MAIDEN NAME OF MOTHER Susan Mitchell

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W.C.Cox.
(Address) Nampa Idaho.

15. Filed April 9 1920 Pearle Dodds Local Registrar

SVMS - YORK CO., PTRS. & SORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 7 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4 1920, to Apr 7 1920, that I last saw her alive on Apr 7th 1920, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Influenza Fever.
(Duration) Yrs. 1 mos. 7 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Jas. B. Brewing M. D.
19..... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem8'
DATE OF BURIAL: 4/9/20 191.....

20. UNDERTAKER: F.F. Robinson
ADDRESS: Nampa

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 29579
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Russell T Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Nov (Month) 28 (Day) 1879 (Year)

7. AGE
40 Yrs. 4 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Ill

10. NAME OF FATHER
Simeon Jones

11. BIRTHPLACE OF FATHER
(State or Country) Ill

12. MAIDEN NAME OF MOTHER
Dorothy Starkey

13. BIRTHPLACE OF MOTHER
(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs R S Jones
(Address) R 2 Boise Ida

15.
Filed April 9 1920 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mch (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1919, to Mch 31 1920, that I last saw h living on Mch 27 1920, and that death occured on the date stated above, at 1 30 P M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis

(Duration) 10 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Uremia
(Duration ..... yrs. ..... mos. 7 ds.

(Signed) M. T. Hallenman M. D.
3/31/1920 (Address) Boise, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: K. L. Cemetery
DATE OF BURIAL: 4/2 1920

20. UNDERTAKER: Fred K. Robertson
ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29580

Registered No. .....

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

Registration District No. 7

Primary Registration District No. 1006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claudie Freemyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.

Nov' (Month) I9 (Day) 1874 (Year)

7. AGE

.....Yrs. 45 .....Mos. .....ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER: Oscar Trussell

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER: ------- Craven

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G.H.Freemyer

(Address) Nampa Idaho.

15.

Filed April 9 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191....., to .....191....., that I last saw h.....alive on April 8 1920, and that death occured on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

.....(Duration) 1 Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. H. Murray M. D.

4/9-1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 4-10 1920

20. UNDERTAKER: F. H. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 3196
File No. 29581
Registered No. 293

1. PLACE OF DEATH.
County of Cassia
City of Raw
(No. R.F.D. #2. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Bodily.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White.	Married.

6. DATE OF BIRTH. June 29 1868
(Month) (Day) (Year)

7. AGE 51 Yrs. 9 Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kaysville Utah.

10. NAME OF FATHER Robert Bodily.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Christine Olsen

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Grace Bodily
(Address) Burley Idaho R.F.D. #2.

15. Filed Mch. 31 1921 D. J. Pettman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 29 Th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 28 1920, to Mar 28 1920, that I last saw him alive on Mar 28 1920, and that death occured on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) F. M. Bailey M. D.

3-25 1921 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL	DATE OF BURIAL
Kaysville Utah	4/1 1920
20. UNDERTAKER	**ADDRESS**
L. B. Gallogly.	Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 24653

FORM V. S. No. 5-12 M. 6-15-17.

Copy

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29582
Registered No. 414

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley

2. FULL NAME Jennie Hawes Parkinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec 13 1866
(Month) (Day) (Year)

7. AGE: 53 Yrs. 7 Mos. 16 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Albert Hawes

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Emily DeSpain

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Parkinson
(Address) .....

15. Filed March 10th 1920. Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 9 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1920 to March 9th 1920 that I last saw h[illegible] alive on March 9 1920 and that death occurred on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:
Obstruction Bowel
following
Surgical Opera (Hysterectomy)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cancer Uterus
(Duration) 2 Yrs. ..... mos. ..... ds.
[redacted] M. D.
[redacted] Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Ida — DATE OF BURIAL: Mar. 11 1920.

20. UNDERTAKER: Kinnath — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

File No. 25383
Registered No. 415

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doyle Corliss Procter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 9 (Day) 1908 (Year)

7. AGE: 11 Yrs. 6 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Afton Wyo

10. NAME OF FATHER: Louis C. Procter

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Florence Ashdown

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Louis C Procter
(Address) Burley Ida

15. Filed March 12 1920 Wm J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1920, to March 11 1920, that I last saw him alive on March 11 1920, and that death occured on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Pneumonia
(Duration ..... yrs. ..... mos. 3 ds.
(Signed) J. C. Patterson M. D.
3-12 1920 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery — DATE OF BURIAL: Mar 13 1920

20. UNDERTAKER: L B Gallogly — ADDRESS: Burley Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

J. C. Patterson

SVMB - YORK CO., PTRS. & BOBS. 24858

FORM V. S. No. 5-12 M. 6-15-17.

Cooper

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29584
Registered No. 416

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Forest Olson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	D

6. DATE OF BIRTH. June (Month) 25 (Day) 1894 (Year)

7. AGE 25 Yrs. 8 Mos. 23 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kas

10. NAME OF FATHER Victor Olson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Edna Coplin

13. BIRTHPLACE OF MOTHER (State or Country) Kas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. Coplin
(Address) Burley Ida

15. Filed March 20 1920 Dr. J. C. Porterfield Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1920 to March 19 1920
that I last saw him alive on March 19th 1920
and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(Duration) ... Yrs. ... mos. 1/2 hour ds.

Contributory (Secondary) Intestinal Obstruction

(Duration) ... Yrs. ... mos. 24 hours ds.

(Signed) C. C. Cooper M. D.

March 20 1920 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery — DATE OF BURIAL March 21 1920

20. UNDERTAKER Rice — ADDRESS Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29586
Registered No. 4

Registration District No. 117
Primary Registration District No. 2196

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)

2. FULL NAME Pearl Inez Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June 23 (Month) (Day) 1919 (Year)

7. AGE: 0 Yrs. 8 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) The Dalles Ore

10. NAME OF FATHER Robert A Young

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Sylvesta Inez McEwen

13. BIRTHPLACE OF MOTHER (State or Country) Weston Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R A Young
(Address) Burley

15. Filed March 22 1920. Dr. J. C. Portteus Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1920 to March 21 1920 that I last saw him alive on March 19 1920 and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows:

1. Bacilar Tumor
2. Possible Abscess
3. .....

(Duration) ... Yrs. ... mos. 10 or more ds.

Contributory (Secondary) Influenza

(Duration) ... Yrs. ... mos. 24 ds.

(Signed) ..... M. D.

3/22 1920 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery — DATE OF BURIAL: March 24 1920

20. UNDERTAKER: Kinnear — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

29587

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 12
County of Cassia Primary Registration District No. 219
City of Oakley (No. ....., ... St.)
File No. XVI
Registered No. 42
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Verda Martindale
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January (Month) 29 (Day) 1915 (Year)

7. AGE: 4 yrs. 11 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W H Martindale

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Sarah Elva Workman

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W Henry Martindale
(Address) Oakley Idah

15. Filed April 1 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1920, to Jany 11 1920 that I last saw her alive on Jany 11 1920, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Influenza
..... (Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Broncho pneumonia
..... (Duration) ..... yrs. ..... mos. 1 ds.
(Signed) Geo L. Crain M. D.
Jany 13 1920 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Id. DATE OF BURIAL: June 6 1920

20. UNDERTAKER: [illegible] ADDRESS: Oakley Id.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29588

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. XVI 3

Registered No. 43

1. PLACE OF DEATH.

County of Cassia

City of Oakley

Registration District No. 13

Primary Registration District No. 2195

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Marie Burke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 27 (Day) 1886 (Year)

7. AGE: 33 Yrs. 8 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Seth Johnson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nellie Schow

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Burke

(Address) Oakley Idaho

15. Filed Apr 7 1920

B F Thacker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1920, to Feb 11 1920, that I last saw h alive on Feb 11 1920, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Pneumonia

(Duration Yrs. mos. 5 ds.

(Signed) B F Thacker M. D.

4/9 1920 (Address) Oakley Id

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Cem

DATE OF BURIAL: Apr 11 1920

20. UNDERTAKER: B F Harper

ADDRESS: Oakley Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMB - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 6-15 M. 1-16-13

CERTIFICATE OF DEATH.

29589 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1st
Primary Registration District No. 249
(No. ..... St.)

File No. 811
Registered No. 44

1. PLACE OF DEATH.
County of Ada
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lula Idaho Lake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single
6. DATE OF BIRTH. July (Month) 4 (Day) 1906 (Year)
7. AGE: 13 Yrs. 7 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: School-girl
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Frank Lake
11. BIRTHPLACE OF FATHER (State or Country): New York
12. MAIDEN NAME OF MOTHER: Melissa Brown
13. BIRTHPLACE OF MOTHER (State or Country): California
14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.
(Informant): Mrs. L. Lake
(Address): Oakley Ida.
15. Filed Apr 9 1920 H. E. Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 14 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920 to Feb 14 1920, that I last saw h alive on Feb 14 1920, and that death occured on the date stated above, at 6A M.
The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos. 16 ds.
Contributory (Secondary) Pneumonia
(Duration ..... yrs. ..... mos. 4 ds.
4/9 1920 (Signed) ..... M. D.
(Address) H. E. Steed

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Cem. DATE OF BURIAL: Feb 16 1920
20. UNDERTAKER: Boyd Stacey ADDRESS: Oakley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29590

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. XVI

Registered No. 48

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Cassia

City of Oakley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12

Primary Registration District No. 3-197

(No. .... St.)

2. FULL NAME Gladys Clark Price

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 23 (Day) 1894 (Year)

7. AGE: 25 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas H Clark

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rachel Hale

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sid Clark

(Address) Oakley, Idaho

15. Filed 4/9 1912

H. H. Hudson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1912 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10 1911, to April 2 1912, that I last saw h[illegible] alive on April 1 1912, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis
Vesicle Epilepsy
(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Gangrenous Appendix
(Duration ..... yrs. 9 mos. ..... ds.

4/9 (Signed) A. F. Walker M. D.

1912 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Ida

DATE OF BURIAL: April 4 1912

20. UNDERTAKER: Pop Harper

ADDRESS: Oakley Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29591 Nelson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 121

Registered No. 47

1. PLACE OF DEATH.

Registration District No. 172

Primary Registration District No. 2199

County of Cassia

City of Oakley

(No. R.F.D. # 2, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniëletta Mabey.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Dec. (Month) 8. (Day) 1861 (Year)

7. AGE: 59 Yrs. 3 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: Daniel Wood.

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. J. Mabey.
(Address) Oakley Ida.

15. Filed Apr 9 — 1920 R. E. Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 27. (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10 1919, to Mar 23 1920, that I last saw h[illegible] alive on Mar 23 1920, and that death occured on the date stated above, at 8.00 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. 10 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. E. Nelson M. D.

1920 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Marion Ida. DATE OF BURIAL: May 30 1920

20. UNDERTAKER: L. B. Falloon ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29592

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 299
File No. XVI
Registered No. 46

1. PLACE OF DEATH.
County of Cassia
City of Oakley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Nahlstrom

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. June (Month) 28 (Day) 1858 (Year)

7. AGE: 2 Yrs. 2 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Albert Nahlstrom

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Bela Skaven

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Nahlstrom
(Address) Oakley Ida.

15. Filed April 9 1920 — A. R. Nelson, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1920, to March 10 1920, that I last saw h[er] alive on March 9 1920, and that death occured on the date stated above, at 9A M.

The CAUSE OF DEATH* was as follows:
Nursing with Pneumonia

(Duration) Yrs. 1 mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) A. R. Nelson M. D.
4/9 1920 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley — DATE OF BURIAL: 3/12 1920

20. UNDERTAKER: By Sessions. — ADDRESS: Oakley Ida

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) ***Grocery;*** (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or ***At home.*** If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite).; *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), ***29 ds.;*** *Bronchopneumonia* (secondary), ***10 ds.*** Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-16-13

29593

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. XX
Primary Registration District No. 2199
(No. ..... St.)

File No. XX 46
Registered No. 46

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Nash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. June (Month) 22 (Day) 1919 (Year)
7. AGE ... Yrs. 8 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: J. N. Nash
11. BIRTHPLACE OF FATHER (State or Country): Wash
12. MAIDEN NAME OF MOTHER: Ada Pirtle
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. N. Nash
(Address) Oakley, Idaho
15. Filed April 9 1919 W. O. Nelson Local Registrar

BYNS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 6 (Day) 1919 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1919, to March 1 1919, that I last saw her alive on Feb 28 1919, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Glandular Tuberculosis

(Duration) ... Yrs. 1 mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) W. O. Nelson M. D.

April 9 1919 (Address) Malta

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: March 13 1919

20. UNDERTAKER: Byington — ADDRESS: Oakley

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

29594 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 2199
File No. XVII
Registered No. 1

1. PLACE OF DEATH.
County of Cassia
City of Basin
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milford Bates

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept 30 (Month) (Day) 1904 (Year)

7. AGE: 10 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Schoolboy
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Erin L. Bates

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Huldah N. Bailey

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Erin L. Bates
(Address) Oakley, Idaho

15. Filed 4/9 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1920, to February 4 1920, that I last saw him alive on February 4 1920, and that death occured on the date stated above, at 7:30 A. M.

The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Lee L. Burns M. D.
Feb 4 1920 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Basin, Idaho — DATE OF BURIAL: 2/6 1920

20. UNDERTAKER: B.P. Harper — ADDRESS: Basin Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 29595
Registered No. 16

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillie Weston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)
6. DATE OF BIRTH: Not Known (Month) 1 (Day) (Year)
7. AGE: about 49 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Dance Hall Girl.
(b) General nature of industry, business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: Not Known
11. BIRTHPLACE OF FATHER (State or Country): Not Known
12. MAIDEN NAME OF MOTHER: Dont Know
13. BIRTHPLACE OF MOTHER (State or Country): dont Know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Tetherow
(Address) Orofino Ida.
15. Filed Apr 20 1920 J. P. Family Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 7 (Month) (Day) 19.....(Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 22 1910, to Mar. 7 1920 that I last saw h[er] alive on Mar. 7 1920 and that death occurred on the date stated above, at 5:35 P.M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

(Duration) probably 20 yrs. ..... mos. ..... ds.

(Signed) John W. Simpson M. D.

3/8 1920 (Address) Orofino Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. 11 mos. 14 days. In the State do not Know yrs. mos. days

Where was disease contracted if not at place of death? do not Know

Former or usual residence Shoshone, Co. Ida.

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery — DATE OF BURIAL: 3/9 1920

20. UNDERTAKER: P. M. Johnson. — ADDRESS: Orofino Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 29596
Registered No. 17

1. PLACE OF DEATH
County of Clearwater
City of Orofino,
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Elizabeth R. Harris.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: ? (Month) ? (Day) ? (Year)

7. AGE: 75 Yrs. ? Mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ?

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. N. Allebery
(Address) Orofino, Ida.

15. Filed Apr 20 1920 J. M. Hinds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 9 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 3 1920, to Mar. 9 1920 that I last saw her alive on Mar. 9 1920, and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:

Uterine Sclerosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John A. Givens M. D.
3/10 1920 (Address) Orofino Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 6 days. In the State 1 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ?
Former or usual residence Sand Point Ida.

19. PLACE OF BURIAL OR REMOVAL: Lew Park Wash. DATE OF BURIAL: 2 1920

20. UNDERTAKER: W. L. Shaw ADDRESS: Orofino Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 40
Primary Registration District No. 2165
File No. 2997
Registered No. 18

1. PLACE OF DEATH
County of Elmore
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emil Hibbeln
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 7 (Day) 1876 (Year)

7. AGE: 44 Yrs. 1 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Jos Hibbeln

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Silva Hibbeln
(Address) Orofino Ida

15. Filed April 1920 — J. M. James, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1920, to March 14 1920, that I last saw h.im alive on March 14 1920, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Pulmonary Tuberculosis

(Duration) ? yrs. ..... mos. ..... ds.

(Signed) J. M. James M. D.

3/13 1920 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Ida	3/14 1920
20. UNDERTAKER	ADDRESS
H. A. Shaw	Orofino

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 29598
Registered No. 19

1. PLACE OF DEATH
County of Elmore
City of Oregon
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cornelia V. Shuler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar (Month) 2 (Day) 1909 (Year)

7. AGE: 11 Yrs. — Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Samuel V. Shuler

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Ethel Smith

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Wheeler
(Address) Oregon Ida

15. Filed Mch 14 1920
J. M. Jones
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 10 1920, to Mar 13 1920, that I last saw her alive on Mar 13 1920, and that death occurred on the date stated above, at 2.55 P.M.
The CAUSE OF DEATH* was as follows:

Acute Meningitis Cerebral

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Jones M. D.
4/14/1920 (Address) Oregon Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sanders Cemetery — DATE OF BURIAL: 3/15 1920

20. UNDERTAKER: W. A. Shaw — ADDRESS: Oregon

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 2959
Registered No. 20

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marilla Keller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	

6. DATE OF BIRTH
April (Month) 17 (Day) 1 (Year)

7. AGE
83 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. E. Valrath
(Address) Orofino Ida

15. Filed Mar 14 1920 J. M. Finch Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 15 1920, to Mar 13 1920, that I last saw h[illegible] alive on Mar 13 1920, and that death occurred on the date stated above, at 9 o'clock A.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Hemorrhage
(Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) Bronchial Asthma
(Duration) 30 yrs. - mos. - ds.
(Signed) J. M. Finch M. D.
Mar 13 1920 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Ida	3/15 1920
20. UNDERTAKER W. A. Chase	ADDRESS Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29600

Registered No. 21

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 3168

County of Clearwater

City of Orofino (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Doe.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH ? (Month) ? (Day) 1 (Year)

7. AGE About 53 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada,

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?,

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. V. Stuberry

(Address) Orofino Ida,

15. Apr 20 1920 J. M. Stanley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH March 21 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby. 10 1913, to Mar. 21 1920, that I last saw him alive on Mar. 21 1920 and that death occurred on the date stated above, at 4-55 P. M.

The CAUSE OF DEATH* was as follows:

Epilepsy.

(Duration) ? yrs. ? mos. ? ds.

Contributory (Secondary) Insanity

(Duration) about 7 yrs. ..... mos. ..... ds.

(Signed) John W. Turner M. D.

3/22 1920 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ? yrs. 1 mos. 11 days. In the State ? yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Cemetery	Mar 24 1920
20. UNDERTAKER	ADDRESS.
Orofino Furn. Co.	Orofino Ida.

ADDRESS 10750

CERTIFICATE OF DEATH

[redacted] Bureau of Vital Statistics

Registration District No. 78 — File No. 29601

Primary Registration District No. 2168 — Registered No. 24

1. **PLACE OF DEATH**

County of Elmore

City of Ashaka (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Lucy Samuels

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Fem	Ind Red	Married (Write the word.)

6. **DATE OF BIRTH** — — — 1.....
(Month) (Day) (Year)

7. **AGE** 76 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Ida

10. **NAME OF FATHER** —

11. **BIRTHPLACE OF FATHER** (State or Country) —

12. **MAIDEN NAME OF MOTHER** —

13. **BIRTHPLACE OF MOTHER** (State or Country) —

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Alex Samuels

(Address) .....

15. Filed Apr 20 1920 — J M Young — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Mar 23 1920
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ..... 19..... **to** ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 12 **M.**
The CAUSE OF DEATH* was as follows:

Had no Physician

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V.A. Shaw Coroner ~~M. D.~~

3/24 1923 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ashaka	3/24 1920
20. UNDERTAKER V.A. Shaw	**ADDRESS** Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 3168
File No. 23602
Registered No. 23

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Nella A. Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
About 1871
(Month) (Day) (Year)

7. AGE
About
49 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Tennessee

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Atteberry
(Address) Orofino, Idaho

15.
Filed Apr 20 1920 J. M. Faris
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 27 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 5th 1920, to Mar. 27 1920, that I last saw her alive on Mar. 27 1920 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Anaemia

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory Insanity
(Secondary)
..... (Duration) ? yrs. ? mos. ? ds.

(Signed) ..... M. D.
19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 22 days. In the State ? yrs. ? mos. ..... days.
Where was disease contracted if not at place of death? I do not Know
Former or usual residence Nez Perce County

19. PLACE OF BURIAL OR REMOVAL Lenore — DATE OF BURIAL 3/28 1920

20. UNDERTAKER W. A. Shaw — ADDRESS Orofino

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 91

Primary Registration District No. 2178

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29603

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clearwater

City of Elk River

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME R. H. Leeper.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

February (Month) 26 (Day) 1889 (Year)

7. AGE

31 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Deputy Sheriff

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Fredericksburg Ohio

10. NAME OF FATHER James B. Leeper.

11. BIRTHPLACE OF FATHER (State or Country) Don't know

12. MAIDEN NAME OF MOTHER Tilla W. Harrison

13. BIRTHPLACE OF MOTHER (State or Country) Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Mae Leeper.

(Address) Elk River Ida.

15.

Filed Feb. 17 1920 Ira Mac Vanderpool Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

February (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza.

Complication Bronchial Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. P. McCormick M. D.

1920 (Address) Elk River

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida.	191...

20. UNDERTAKER	ADDRESS
H. E. Hunt	St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 91
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 29604
Registered No. .....

1. PLACE OF DEATH.
County of Clearwater
City of Elk River

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vernon Crane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August (Month) 29 (Day) 1904 (Year)

7. AGE: 15 Yrs. 5 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Emmons Crane

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Lizzie Sibrina

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs A. Crane Sister
(Address) Elk River Ida

15. Filed April - 16 1920 Ida MacGarvey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febru 12 1920, to Feb 19 1920, that I last saw h[illegible] alive on Feb 19 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Influenza
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) F. P. McConnell M. D.
1920 (Address) Elk River Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River Ida — DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: Moore — ADDRESS: Elk River

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 91
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 29605
Registered No. .....

1. PLACE OF DEATH.
County of Clearwater
City of Elk River

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Mc Donald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
not known (Month) 1 (Day) (Year)

7. AGE
19 Yrs. not known Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Allmville Mich

10. NAME OF FATHER
Samuel Burton McDonald

11. BIRTHPLACE OF FATHER
(State or Country) Algomah Canada

12. MAIDEN NAME OF MOTHER
not known

13. BIRTHPLACE OF MOTHER
(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George D. Cowdrey
(Address) Post Falls Idaho

15.
Filed Feb. 24 1920 Ida May Vandaveer Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February 20 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 13 1920, to February 20 1920, that I last saw h/M alive on February 20 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Influenza
complicated Pneumonia Bronchial
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. P. McConnell M. D.
Feb 24 1920. (Address) Elk River Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Post Falls Idaho
DATE OF BURIAL: Feb 25 1920

20. UNDERTAKER: Hurst
ADDRESS: St Maries Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29606
Registered No. ____

1. PLACE OF DEATH.
County of Clearwater
City of Elk River
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 91
Primary Registration District No. 2168

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Prof J A Silbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH. Not Known (Month) (Day) 1 (Year)

7. AGE 65 Yrs. ____ Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Music teacher
(b) General nature of industry, business, or establishment in which employed (or employer)... Not Known

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER Hebert

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) ____
(Address) ____

15. Filed April 16 1920 Ida MacDonagan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH February (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 8th 1920, to Feb 12th 1920, that I last saw h/m alive on February 12 1920, and that death occured on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(Duration) ____ Yrs. ____ mos. 7 ds.
Contributory (Secondary) Influenza
(Duration ____ yrs. ____ mos. 7 ds.
(Signed) F P McCormick M. D.
1920 (Address) Elk River Ida.

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Elk River Idaho — DATE OF BURIAL: Feb 15th 1920

20. UNDERTAKER: Morris — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 91
Primary Registration District No. 2168
File No. 29607
Registered No. .....

1. PLACE OF DEATH.
County of Clearwater
City of Elk River
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gus Pelizis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Not Known (Month) ..... (Day) 1 (Year)

7. AGE
25 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Lumber Woods

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed April 16 1920 Wm Mac Vanderburg Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
February (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 9 1920, to Feb 14 1920, that I last saw h/M alive on Feb 14 1920 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. P. McCormick M. D.
19 ..... (Address) Elk River Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River Ida
DATE OF BURIAL: February 19 1920

20. UNDERTAKER: Morris
ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clark
City of Dubois
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 125
Primary Registration District No. 2203
(No. ..... St.)

File No. 29608
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Castle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): widowed

6. DATE OF BIRTH: X (Month) 5 8 (Day) 27 23 (Year) 1858 1920

7. AGE: 61 yrs. 8 mos. 25 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Mich.

10. NAME OF FATHER S. G. Hutchins

11. BIRTHPLACE OF FATHER (State or Country) Mass.

12. MAIDEN NAME OF MOTHER Rebecca Kilpatrick

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Burnhams
(Address) Dubois, Idaho

15. Filed March 10 1920 C E Jones MD Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
2 (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24, 1920, to Feby 23rd 1920
that I last saw her alive on Feby 22nd 1920
and that death occurred on the date stated above, at 9A. M.

The CAUSE OF DEATH* was as follows:
Mitral Regurgitation
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Rheumatism
..... (Duration) do not know. yrs. ..... mos. ..... ds.

(Signed) A. Howard Young M.D.
2/4 1920 (Address) Dubois Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello, Idaho. DATE OF BURIAL ..... 191..

20. UNDERTAKER: Hoyes, of Ida. Falls ADDRESS Ida. Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 125

Primary Registration District No. 2203

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29609

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Jefferson

City of Camas (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laird Jolley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Child

6. DATE OF BIRTH: Nov (Month) 20 (Day) 1904 (Year)

7. AGE: 10 yrs. 4 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Robert L Jolley

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Ellen Scheets

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt L Jolley
(Address) Camas

15. Filed March 25 1920 C E Jones M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 8, 1920, to Mch 24 1920, that I last saw h[illegible] alive on March 22 1920 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

several yrs
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) C E Jones M. D.

3/25 1920 (Address) Rubicon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Camas Idaho — DATE OF BURIAL: 3/25 1920

20. UNDERTAKER: None — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19750

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clark
City of Dubois
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 125
Primary Registration District No. 2203
(No. ....., ... St.)

File No. 29610
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Raymond Lorin Hipsher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Baby

6. DATE OF BIRTH
X (Month) Jl (Day) X4 1920 (Year)

7. AGE
..... yrs. 3 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Pocatello, Ida.

10. NAME OF FATHER Raymond Hipsher

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Sylvia Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Raymond Hipsher
(Address) Dubois, Ida.

15. Filed March 10 1920 C E Jones M D Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
3 (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/8 1920, to 3/8 1920 that I last saw him alive on March 8, 1920 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
(Duration) ..... yrs. ..... mos. 6 ds.
Contributory (Secondary) Cold
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Howard Jones M D
3/10 1920 (Address) Dubois, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho — DATE OF BURIAL: 3/9 1920

20. UNDERTAKER: None. — ADDRESS:

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No. 2203
File No. 29611
Registered No.

1. PLACE OF DEATH.
County of Jefferson
City of Camas
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth Barnard Johnson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 8 (Month) 8 (Day) 1904 (Year)

7. AGE: 16 yrs. 6 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Barnard Johnson

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Mary Ann Reynolds

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Barnard Johnson
(Address) Camas

15.
Filed March 10 1920
C E Jones M.D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
2 (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/9 1920, to 2/23 1920, that I last saw him alive on 2/23 1920, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
A burn whereby the skin of the neck & face, back and right leg below the knee & both hands and abdomen was all gone
(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
(Duration) — yrs. — mos. — ds.

(Signed) A Howard Jones M.D.
3/10 1920 (Address) Dubois, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Camas DATE OF BURIAL: 3/24 1920

20. UNDERTAKER: Hoyes ADDRESS: Idaho Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29612
Registered No.

1. PLACE OF DEATH.
County of Canas
City of Manard.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 58th
Primary Registration District No. 2138
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Effie May Reagan.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH: Feb 10th 1907 (Month) (Day) (Year)

7. AGE: 13 yrs. 1 mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: School-girl.
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: L.E. Reagan

11. BIRTHPLACE OF FATHER (State or Country): U.S. (Tenn.)

12. MAIDEN NAME OF MOTHER: Eliz. Chandler

13. BIRTHPLACE OF MOTHER (State or Country): U.S. (Tenn)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L E Reagan
(Address) Manard, Idaho.

15. Filed April 6 1920. L Wilencheck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1920, to March 27 1920 that I last saw h[er] alive on March 27 1920, and that death occurred on the date stated above, at 6 00 P M.

The CAUSE OF DEATH* was as follows:
Bilateral Lobar Pulmonia

..... (Duration) ..... yrs. ..... mos. 10. ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Wilencheck M. D.
April 6 1920 (Address) Fairfield, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29614

Registered No.

1. PLACE OF DEATH

County of Custer

City of Ramshorn Mine

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 108

Primary Registration District No. 2186

(No. ..... , ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anthony Doherty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Not known (Month) ..... 1 (Day) ..... (Year)

7. AGE: About 30 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed April 1st 1920

L. L. Kirtley
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 31st. 1920 (Month) (Day) (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Died without medical attendance 19 ....., that I last saw h..... alive on ..... 19 ....., and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

I beleive that the man died from Pneumonia.

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

4/1 19.20 (Address) Challis, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Butte, Mont

DATE OF BURIAL 19

20. UNDERTAKER: W. C. Doebler

ADDRESS: Salmon, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25615

Registration District No. 108

Primary Registration District No. 2186

Registered No.

1. PLACE OF DEATH

County of Custer

City of Challis (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Kleupfer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	Wh.	Widowed

6. DATE OF BIRTH

May (Month) 4th. (Day) 1856 (Year)

7. AGE

66 Yrs. 10 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work H-wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Sweden

10. NAME OF FATHER Nels Larsen

11. BIRTHPLACE OF FATHER

(State or Country) Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER

(State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Johnson

(Address) Challis, Idaho.

15.

Filed 3/10 1920

C. L. Kirkley
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March (Month) 10th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/20/1919 ~~1920~~, to 3/~~30~~ 9/1920 19....., that I last saw h~~er~~ alive on 3/9 10P. 19....., and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

.....(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Uremia

.....(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) ..... M. D.

3/10 19 20 (Address) Challis, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Challis, Ida.	3/12 1920
20. UNDERTAKER Family	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29617
Registered No. .....

1. PLACE OF DEATH.
County of Custer
City of Mackay
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 76
Primary Registration District No. 2153

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME E S Crawford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married
6. DATE OF BIRTH: June 19 1864 (Month) (Day) (Year)
7. AGE: 53 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer and
(b) General nature of industry, business, or establishment in which employed (or employer): stock raiser.
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: James F Crawford
11. BIRTHPLACE OF FATHER (State or Country): Indiana
12. MAIDEN NAME OF MOTHER: Margret Spurgeon
13. BIRTHPLACE OF MOTHER (State or Country): Iowa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....
15. Filed Apr. 8th 1920 Rose Mowrer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 12th 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 31 1919, to Feb. 12 1920, that I last saw h.. alive on Feb. 4 1920, and that death occured on the date stated above, at 8 a. M.
The CAUSE OF DEATH* was as follows:
Chronic Bright's disease
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) M H Tamm M. D.
19..... (Address) Mackay Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....
20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
(No. ....., ... St.)

File No. 29618
Registered No. .....

1. PLACE OF DEATH.
County of Custer
City of Macray

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie McKelvey.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 11 (Month) 11 (Day) 1864 (Year)

7. AGE: 65 Yrs. 2 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: John Bonner

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Emma Gildeas

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James McKelvey
(Address) Macray, Idaho

15. Filed Apr. 8th 1920. Rose Mourer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/9 1920, to 2/16 1920 that I last saw h[illegible] alive on 2/16 1920 and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Lobar, Double.

(Duration) - Yrs. - mos. 5 ds.

Contributory (Secondary): Senility.

(Duration) Years yrs. ..... mos. ..... ds.

(Signed) F. P. Richards M. D.

2/19 1920 (Address) Macray, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
File No. 29619
Registered No. .....

1. PLACE OF DEATH.
County of Custer
City of Leslie
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Martha Gilbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. (Month) (Day) (Year): Don't Know
7. AGE: 44 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: Dent
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edgar Gilbert
(Address) Leslie Ida.
15.
Filed Apr. 8th 1920 Rose Nowacki Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 26" 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 26" 1920, to March 26 1920, that I last saw her alive on March 26" 1920 and that death occured on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Eclipsed Birth
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia
(Duration) 1/2 yrs. About mos. ..... ds.
(Signed) Theo Baker M. D.
19..... (Address) Marsing Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Leslie
DATE OF BURIAL: 3/31 1920
20. UNDERTAKER: None
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Custer

City of White Knob

Registration District No. 76

Primary Registration District No. 2153

(No. ....., ... St.)

File No. 29620

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse W Weireman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. X: June (Month) 23 (Day) 1883 (Year)

7. AGE X: Yrs. 36 Mos. 7 ds. 29

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE X (State or Country): Indiana

10. NAME OF FATHER X: Jesse W. Mumbower.

11. BIRTHPLACE OF FATHER X (State or Country): Indiana

12. MAIDEN NAME OF MOTHER X: Martha Study

13. BIRTHPLACE OF MOTHER X (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Weireman

(Address) White Knob Idaho

15. Filed Apr. 8th 1920 Rose Mower Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH X: February (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15 1920, to Feb. 21 1920, that I last saw her alive on Feb. 20 1920, and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic myocardial disease of heart. Fatty degeneration?

..... (Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) W. H. Farrell M. D.

2/28 1920 (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Custer

City of Chilly

(No. ..... St.)

Registration District No. 76

Primary Registration District No. 2153

File No. 29621

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo. L. Childs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	Caucasian	Married.

6. DATE OF BIRTH. Aug (Month) 19 (Day) 1881 (Year)

7. AGE 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah.

10. NAME OF FATHER P. A. Childs.

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Agnes Fulmer.

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. A. B. Childs.

(Address) Chilly, Ida.

15. Filed Apr. 8th 1920 Rose Mower Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1920, to Feb. 11 1920, that I last saw him alive on Feb. 10 1920, and that death occured on the date stated above, at 8. a M.

The CAUSE OF DEATH* was as follows:

Bobular Pneumonia.

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Influenza

..... (Duration) ..... Yrs. ..... mos. 4 ds.

(Signed) W. W. Farrell M. D.

19..... (Address) Mackay Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 191 .....
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 54

Primary Registration District No. 020

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29622

Registered No. 73

1. PLACE OF DEATH

County of Elmore

City of Mtn Home (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Zoe Avis Clayville

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX ~~M~~ F.

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED child (Write the word.)

6. DATE OF BIRTH Sept 26 - 1908 (Month) (Day) (Year)

7. AGE 11 Yrs. 5 Mos. 5 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Denver Colo.

10. NAME OF FATHER Walter D. Clayville

11. BIRTHPLACE OF FATHER (State or Country) Farber Mo.

12. MAIDEN NAME OF MOTHER Nellen Horner

13. BIRTHPLACE OF MOTHER (State or Country) Denver Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter D. Clayville

(Address) Mtn Home Ida

15. Filed March 4th 1920 W Walker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~February 29, 1920~~ March 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr. 22 1920, to March 3 1920 that I last saw h-er alive on Mar. 2 1920 and that death occurred on the date stated above, at 4.00 P.M.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

.....(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) Acute Rheumatism

.....(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) J. E. Evans M. D.

3-6-1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mountain Home | **DATE OF BURIAL** 3-4 1920

20. UNDERTAKER A W Conner | **ADDRESS** Mtn Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 29623
Registered No. 12

1. PLACE OF DEATH
County of Elmore
City of Mountain Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachael Sethen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: June 24th (Month) (Day) 1870 (Year)

7. AGE: 49 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Matias

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Gunaell

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennie Sethen
(Address) Mountain Home, Idaho

15. Filed March 28th 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 23 1920, to March 27 1920, that I last saw her alive on March 26 1920 and that death occurred on the date stated above, at 4:30 M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) J E Evans M. D.
3-27-1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida
DATE OF BURIAL: 3-28-1920

20. UNDERTAKER: A. W. Conover
ADDRESS: Mtn. Home

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 29624
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Glenns Ferry
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Cecelia McEvoy
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July — 9 — 1890 (Month) (Day) (Year)

7. AGE: 29 Yrs. 7 Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: John J. Kildare

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas McEvoy
(Address) Glenns Ferry Idaho

15. Filed March 8 1920 — F. W. Harris, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 5 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from F. 6. 22 1922, to March 5 1920 that I last saw her alive on March 5 1920, and that death occurred on the date stated above, at 11 4 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) F. W. Davis M. D.
3/8 1920 (Address) Glenns Ferry, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogalalla, Neb. — DATE OF BURIAL: March 1 1920

20. UNDERTAKER: C W McCartney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 35
Primary Registration District No. 2021
File No. 29020
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Mountain Home
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Mae Lindsey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 18 (Day) 1893 (Year)

7. AGE: 27 Yrs. 9 Mos. 8 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rankin Co., Mississippi

10. NAME OF FATHER: Ernest Nobles

11. BIRTHPLACE OF FATHER (State or Country): Mississippi

12. MAIDEN NAME OF MOTHER: Cases Bridges

13. BIRTHPLACE OF MOTHER (State or Country): Mississippi

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. [illegible]
(Address) Mountain Home

15. Filed Feb. 27 1920 J. W. Davis Local Registrar

[illegible], PRINTERS & BINDERS, BOISE

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 24th 1920, to Feb. 26 1920, that I last saw her alive on Feb. 26 1920, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia
(Duration) Yrs. mos. ds.
Contributory (Secondary): Influenza
(Duration) yrs. mos. ds.

(Signed) J. W. Davis M. D.
Feb. 27 1920. (Address) Elmore County Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morton Mississippi
DATE OF BURIAL: Feb. 28. 1920

20. UNDERTAKER: Wm McBratney
ADDRESS: Boise Idaho

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 35

County of Elmore Primary Registration District No. 2021 File No. 29627

City of Glenn's Ferry (No. ....., ... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Catharina West

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: March 16th 1920 (Month) (Day) (Year)

7. AGE: 87 yrs. 11 mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: Joseph Davis

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Linn

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Chas Smith
(Address) Pocatello Idaho

15. Filed March 1st 1920 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 1st 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26th 1920, to March 1st 1920 that I last saw her alive on February 29 1920, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

..... (Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Senility

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.
March 1st 1920 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Idaho | DATE OF BURIAL: March 1st 1920

20. UNDERTAKER: Wm McBratney | ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

WING-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29628
Registered No.

1. PLACE OF DEATH.
County of Elmore
City of Elmer's Ferry
Registration District No. 35
Primary Registration District No. 2021
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Pussie M. Slade
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: March (Month) 1st (Day) 1920 (Year)

7. AGE: 2 yrs. 8 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) American

10. NAME OF FATHER Jesse E. Slade

11. BIRTHPLACE OF FATHER (State or Country) Mississippi

12. MAIDEN NAME OF MOTHER Lizzie Mae Nobel

13. BIRTHPLACE OF MOTHER (State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jessie E. Slade
(Address) Elmer's Ferry Idaho

15.
Filed March 13 1926 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Elmer's Ferry Idaho March 1st 1926 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 25 1926, to March 1st 1926, that I last saw her alive on Feb. 29 1926, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.
March 13 1926 (Address) Elmer's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morton Mississippi — DATE OF BURIAL: Mar 13 1926

20. UNDERTAKER: Wm McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 35
Primary Registration District No. 2021
File No. 29629
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Glenns Ferry
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catharine Thompson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6. DATE OF BIRTH Jan 24 1884
(Month) (Day) (Year)

7. AGE 36 Yrs. — Mos. 27 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Michael Corcoran

11. BIRTHPLACE OF FATHER (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Mary McCarty

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Ruebsam
(Address) Glenns Ferry

15. Filed Feb. 22nd 1920 J. W. Dorris
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb. 21st 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 16th 1920, to Feb. 21st 1920, that I last saw her alive on Feb. 21st 1920, and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:

Bronchopneumonia
following Influenza

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 1 ds.

(Signed) J. W. Dorris M. D.
Feb 22, 1920 (Address) Glenns Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise Idaho	2/24 1920
20. UNDERTAKER	ADDRESS
W. M. Pratney	Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ..... File No. 29630

Primary Registration District No. ..... Registered No. .....

1. PLACE OF DEATH

County of Elmore

City of Glenns Ferry (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laurel Marcellus Buckley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female.	White.	Married

6. DATE OF BIRTH Aug 10 — 1896
(Month) (Day) (Year)

7. AGE 33 Yrs. 6 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) California

10. NAME OF FATHER Joe Weaver

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Eva Brown

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ida Buchanan
(Address) Glenns Ferry Idaho

15.
Filed March 6 1920 J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mch. 4 — 1920
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26 1920, to March 4, 1920, that I last saw h... alive on March 4 1920, and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.
3/6/20 19 (Address) Glenns Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida	March 19 20

20. UNDERTAKER	ADDRESS
W. M. Bradley	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2117
File No. 29631
Registered No. 20

1. PLACE OF DEATH.
County of Franklin
City of Weston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Metta C Georgeson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (Month) 6 (Day) 1858 (Year)

7. AGE: 60 Yrs. 10 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: James Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna K Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Heber M. Georgeson
(Address) Weston, Idaho

15. Filed Mar 3 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1920, to Mar 29 1920, that I last saw her alive on March 27 1920, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Rheumatism of Heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Holder M. D.
(Address) Weston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weston | DATE OF BURIAL: Apr 1 1920

20. UNDERTAKER: C. A. Lundquist | ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29632
Registered No. 28

1. PLACE OF DEATH.
County of Franklin
City of Fairview

Registration District No. 27
Primary Registration District No. 211E
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes McLean

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: January 27 1918 (Month) (Day) (Year)

7. AGE: 2 yrs. 11 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION (Child only)
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (City or Town) Franklin Co Idaho (State or Country)

10. NAME OF FATHER Elmer McLean

11. BIRTHPLACE OF FATHER (State or Country) Fairview Idaho

12. MAIDEN NAME OF MOTHER Jennie Durant

13. BIRTHPLACE OF MOTHER (State or Country) Franklin Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer McLean
(Address) Fairview Franklin Co Idaho

15. Filed Apr 8 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Febr. 25 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr 21 1920, to Febr 25 1920 that I last saw her alive on Febr 24 1920 and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Influenza followed by Pneumonia

..... (Duration) ..... yrs. ..... mos. 10 ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Yates M. D.
Febr 26 1920 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Franklin Ida
DATE OF BURIAL: Feb 27 1920

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

STAR-TIMES CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25035

Registered No. 24

1. PLACE OF DEATH

County of Franklin

City of Dayton

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2119

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Goodwin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Mar 9 1886 (Month) (Day) (Year)

7. AGE: 33 Yrs. 11 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dayton

10. NAME OF FATHER: Wm Phillips

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Matilda Perry

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Goodwin

(Address) Dayton, Idaho

15. Filed apr 8 1920 D. A. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 6 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1920, to March 6 1920, that I last saw h.r alive on March 4 1920, and that death occurred on the date stated above, at 1.45a M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — Yrs. 2 mos. 7 ds.

Contributory (Secondary) Influenza

(Duration) — yrs. — mos. 4 ds.

(Signed) Curtis Blank M. D.

3/6/1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Dayton

19. PLACE OF BURIAL OR REMOVAL: Dayton | DATE OF BURIAL: 3/8 1920

20. UNDERTAKER: [illegible] | ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD-TOOKE CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2112
File No. 29634
Registered No. 27

1. PLACE OF DEATH
County of Franklin
City or Fairview
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eduin Bodily Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Oct. 16 1875 (Month) (Day) (Year)

7. AGE: 44 Yrs. 6 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fairview

10. NAME OF FATHER: Eduin Bodily

11. BIRTHPLACE OF FATHER (State or Country): Africa

12. MAIDEN NAME OF MOTHER: Matilda Roberts

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eduin Bodily Sr.
(Address) Fairview Idaho

15. Filed Apr 3 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51988

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 22 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1920, to March 22 1920, that I last saw h.him alive on March 21 1920, and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:
Influenza - Pneumonia

(Duration) — Yrs. — mos. 11 ds.

Contributory (Secondary): —
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W States M. D.
May 25 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview — DATE OF BURIAL: May 25 1920

20. UNDERTAKER: C C Lundquist — ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 9635
Registered No. 25

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Georgia Manning
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	white	~~(Write the word.)~~

6. DATE OF BIRTH
Feb. 18 (Month) ..... (Day) 1912 (Year)

7. AGE
..... Yrs. ..... Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Preston Idaho

10. NAME OF FATHER Virgil Manning

11. BIRTHPLACE OF FATHER
(State or Country) Preston Idaho

12. MAIDEN NAME OF MOTHER Alice Ann Jones

13. BIRTHPLACE OF MOTHER
(State or Country) Weston Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Manning
(Address) Preston Idaho

15.
Filed Apr 3 1920 Dick Rudd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 8 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1920, to March 8th 1920, that I last saw her alive on March 5th 1920, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Allen Rees M. D.
3/8 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	Mar 9 1920
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 29636
Registered No. 26

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ann Merrill
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: Sept 19 1845 (Month) (Day) (Year)

7. AGE: 71 Yrs. 5 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Robert Ruck

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Brown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ward Evans
(Address) Preston

15. Filed Apr 8 1920 Dora R Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 8 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1919, to March 8 1920
that I last saw h.... alive on March 7 1920,
and that death occurred on the date stated above, at 1:27 P.M.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis

.....(Duration) ✓ Yrs. ..... mos. ..... ds.
Contributory (Secondary)
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Rand M. D.
3/9 1920 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston | DATE OF BURIAL: 3/9 1920

20. UNDERTAKER: G A Lindquist | ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 29637
Registered No. 27

1. PLACE OF DEATH.
County of Franklin
City of Weston Idaho (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leland C Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept 1 1919 (Month) (Day) (Year)

7. AGE: Yrs. 6 Mos. 6 ds. 8
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE
(~~State or~~ Country) Franklin

10. NAME OF FATHER John Jensen

11. BIRTHPLACE OF FATHER
(~~State or~~ Country) Franklin Co

12. MAIDEN NAME OF MOTHER Dora Clements

13. BIRTHPLACE OF MOTHER
(State or Country) Oxford Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Jensen
(Address) Weston Idaho

15.
Filed Apr 8 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23 1920, to March 9 1920, that I last saw him alive on March 9 1920, and that death occured on the date stated above, at 10:15 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Holden M. D.
19..... (Address) Weston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston — DATE OF BURIAL: 3/12 1920

20. UNDERTAKER: [signature] — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29638

Registered No. 28

1. PLACE OF DEATH.

Registration District No. 27

Primary Registration District No. 2119

County of Franklin

City of Preston Idaho (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Verda Twitchell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Nov (Month) 11 (Day) 1917 (Year)

7. AGE: 2 Yrs. 4 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.? ←

8. OCCUPATION

(a) Trade, profession or particular kind of work... ←

(b) General nature of industry, business, or establishment in which employed (or employer)... ←

9. BIRTHPLACE (State or Country) Beaver Dam Utah

10. NAME OF FATHER Charles E Twitchell

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake City Ut

12. MAIDEN NAME OF MOTHER Susan P Elmer

13. BIRTHPLACE OF MOTHER (State or Country) American Falls Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C E Twitchell

(Address) Preston Idaho

15. Filed 3/23 1920 D A Allred Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1920, to March 22 1920, that I last saw her alive on March 22 1920 and that death occured on the date stated above, at 4:40 P.M.

The CAUSE OF DEATH* was as follows:

Tonsaine Paisions

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) ←

(Duration ← yrs. ← mos. ← ds.

(Signed) Thos B Holden M. D.

3/23 1920 (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Beaver Dam, Utah — DATE OF BURIAL: Mar 25 1920

20. UNDERTAKER: G A Lundquist — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29639

Registered No.

Registration District No. 99

Primary Registration District No. 2199

1. PLACE OF DEATH

County of Fremont

City of Sugar City Ida

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Birch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH

Dec (Month) 10 (Day) 1856 (Year)

7. AGE

63 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER James Birch

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Hale

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) David Burch

(Address) St Anthony Idaho

15.

Filed Mar 10 1920

W R Wood
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Phy Sician to the attendance

that I last saw h..... alive on ..... 19....,

and that death occurred on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:

Was Probably Some Cardiac Trouble

..... (Duration) 3 Hours mos. ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W R Wood M. D.

19..... (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wilford Ida.	Mar 30 1920
20. UNDERTAKER	**ADDRESS**
J. R. Young.	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9 0

Primary Registration District No. 2 1 7 7

File No. 29640

Registered No.

1. PLACE OF DEATH

County of Bannock

City of St Anthony

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Irene Bird

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	single

6. DATE OF BIRTH: 6 (Month) 10 (Day) 1919 (Year)

7. AGE: Yrs. 9 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: A B Bird

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Maud Owen

13. BIRTHPLACE OF MOTHER (State or Country): Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Woodall
(Address) St Anthony Ida

15. Filed Nov 10 1920 W A Wurst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 4 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw her alive on 3/3 19 20,
and that death occurred on the date stated above, at 11 A M.
The CAUSE OF DEATH* was as follows:—
Found dead in bed no
diagnosis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jno P Kray M. D.
3/4/1920 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rudolph Wilford — DATE OF BURIAL: Nov 6 1920

20. UNDERTAKER: none — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-15-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 29641
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of Teton
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George V. Cunningham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept 4 (Month) (Day) 1902 (Year)

7. AGE: 18 Yrs. 6 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George J. Cunningham

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary L. Hamer

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo J Cunningham
(Address) Newdale Idaho

15.
Filed Apr 10 1920
W. P. Wilcox
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1920, to Mar 25 1920, that I last saw him alive on Mar 25 1920 and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Acute Appendicitis Gangrenous

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Peritonitis general
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) C. Eames M. D.
Mar 27 1920 (Address) Teton City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Newdale — DATE OF BURIAL: 3/28 1920

20. UNDERTAKER: J A Young — ADDRESS: Parley

N. B.—Every item should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 29642
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of Teton
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry A Bird

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 16 (Day) 1899 (Year)

7. AGE: 30 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Teton Idaho

10. NAME OF FATHER: Jonathan F Bird

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Hannah A Willey

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary M. Bird
(Address) Teton

15. Filed Mar 10 1920 W A Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1920, to Mar 14 1920, that I last saw h~~e~~r alive on Mar 14 1920, and that death occured on the date stated above, at 6 12 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 1 6 ds.
Contributory (Secondary) Pneumonia
(Duration ..... yrs. ..... mos. 2 ds.

(Signed) E. Eames M. D.
3 1920 (Address) Teton City, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191

20. UNDERTAKER J Rigsway | ADDRESS Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29643
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99
Primary Registration District No. 2177.
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annie Miller.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1863 (Year)

7. AGE: 57 Yrs. 1 Mos. 23 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer's wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Farmington Utah

10. NAME OF FATHER: Truman Leonard

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Meadows

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): H. W. Miller
(Address): St Anthony

15. Apr 10 28
Filed Mar 29 1928
W. A. Wirt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1920, to Mar. 28 1920
that I last saw her alive on Mar 24 1920
and that death occurred on the date stated above, at 9 A M.
The CAUSE OF DEATH* was as follows:
Pernicious Anemia
(Duration) ..... Yrs. 7 mos. — ds.
Contributory (Secondary) Mitral Insufficiency
(Duration) / yrs. ..... mos. ..... ds.
(Signed) J E Nelson M. D.
3/29 1928 (Address) St Anthony J E Nelson

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker, Idaho
DATE OF BURIAL: Mar 31 1920

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 29644
Registered No. .....

1. PLACE OF DEATH.
County of Fremont
City of Parker
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lyman C. Parker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widwr

6. DATE OF BIRTH. March (Month) 13 (Day) 1839 (Year)

7. AGE: 80 Yrs. 11 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Thomas Green

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Caroline Whitney

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. L. West
(Address) Parker

15. Filed Oct 10 1917 W. L. West Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 7 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at no time during per last illness, that I last saw h alive on Oct 7 1917, and that death occured on the date stated above, at 4:30a M.

The CAUSE OF DEATH* was as follows:
Old Age

(Duration) Yrs. 1 mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Pratt M. D.
19..... (Address) Dawson Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker — DATE OF BURIAL: Oct 9 1917

20. UNDERTAKER: J. R. Young — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29645
Registered No.

Registration District No. 99
Primary Registration District No. 2127
(No. ..... St.)

1. PLACE OF DEATH
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Elizabeth Bailey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 6 (Day) 1861 (Year)

7. AGE: Yrs. 58 Mos. 8 ds. 12
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business or establishment in which employed (or employer): Missouri

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Alpheus Butler

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Katherine Miller

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dowed L. Bailey
(Address) St. Anthony Idaho

15. Filed [redacted] 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1919 to Mar 16 1920
that I last saw her alive on Mar 17 1920
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:
Carcinoma Pancreas and Liver.
(Duration) Yrs. 4 mos. ds.
Contributory (Secondary) Jaundice Obstructive
(Duration) yrs. 3 mos. ds.
(Signed) J. C. Metton M. D.
3/20 1920 (Address) St Anthony, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 13 yrs. mos. days. In the State 13 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence St Anthony Ida

19. PLACE OF BURIAL OR REMOVAL: Rea Missouri — DATE OF BURIAL: upon arrival 1920

20. UNDERTAKER: Taylor Elerson Studebo — ADDRESS: St Anthony Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29646

Registration District No. 102
Primary Registration District No. 6
(No. ..... St.)
Registered No. 1

1. **PLACE OF DEATH**
County of Fremont
City of Ashton, Ida.
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Fred Emanuel Swanstrom
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** male.

4. **COLOR OR RACE** white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** X (Write the word.)

6. **DATE OF BIRTH** 3 (Month) 3 (Day) 1920 (Year)

7. **AGE** ..... Yrs. ..... Mos. 28 ds.
IF LESS than 1 day how many X hrs. or X min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work X
(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Ashton (Fremont Co.) Ida.

10. **NAME OF FATHER** Fred T. Swanstrom

11. **BIRTHPLACE OF FATHER** (State or Country) Bennehead Co. Mont.

12. **MAIDEN NAME OF MOTHER** Margaret Swanstrom

13. **BIRTHPLACE OF MOTHER** (State or Country) North Dakota

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Freeman A. Hayes
(Address) Ashton Idaho

15. Filed 3/31 1920. C. M. Graham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** 3 (Month) (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Feb 2 (3/30), 1920, to Feb 3 3/3 1920 **that I last saw him alive on** Feb 28 3/3 1920 **and that death occurred on the date stated above, at** 4 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Congestion

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Hayes M. D.
3/3 1920 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ashton, Ida.	3/31 1920
20. UNDERTAKER Leo C. Lenhart	**ADDRESS** Ashton Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29647

Registered No.

1. PLACE OF DEATH.
County of Ada
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1010
Primary Registration District No.
(No. ..., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Lois May Davenport

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Infant

6. DATE OF BIRTH
March 25 1920
(Month) (Day) (Year)

7. AGE
— yrs. — mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work Infant
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L. A. Davenport

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Susie Lutz

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L A Davenport
(Address) Emmett Ida

15.
Filed Apr 7 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar 31 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 25 1920, to Mar 31, 1920 that I last saw h.er alive on Mar 31 1920, and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Burton O Clark M. D.
4/9/ 1920 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rexburg Ida
DATE OF BURIAL ... 191...

20. UNDERTAKER C D Buckmun
ADDRESS Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10 20
Primary Registration District No.
File No. 29648
Registered No.

1. PLACE OF DEATH
County of Kootenai
City of Ola
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Attilla W. Beach

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 26 (Day) 1868 (Year)

7. AGE: 58 Yrs. 11 Mos. 25 ds.
IF LESS than 1 day: how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Black Earth, Wis.

10. NAME OF FATHER: Joseph Beach

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sherman Kleppe
(Address) Ola Ida.

15.
Filed Mar 16 1920
J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Possibly Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. L. Reynolds M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ola Cemetery
DATE OF BURIAL: 3/12 1920

20. UNDERTAKER: None
ADDRESS: Ola Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 1610
County of Gem Primary Registration District No.
City of Emmett (No. , (St.) File No. 29649
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Infant Boy Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Mar (Month) 30 (Day) 1920 (Year)

7. AGE: new Born yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: F. C. Pattinieri

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Viola Gray

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. C. Pattinieri
(Address) Emmett Ida

15. Filed Apr 2 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30 1920, to March 31 1920 that I last saw h alive on March 31 192, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Premature Infants
Cardiac Failure

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. G. Ward M. D.
4-2 1920 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida
DATE OF BURIAL: 4/2 1920

20. UNDERTAKER: C. R. Buckman
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 10 10
County of Gem Primary Registration District No.
City of Emmett (No. ; St.) File No. 29650
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Sarah J. Kenady Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1844 (Year)

7. AGE: 75 yrs. 3 mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: James Stinson

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. J. Couch
(Address) Emmett Idaho

15. Filed Mch 7 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 16 1919 to death and from personal knowledge and observation I state that I last saw her alive on Mar 29 1920, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Probably a Leukemia but I do not know

(Duration) Two yrs. mos. ds.

Contributory (Secondary) ✓

(Duration) yrs. mos. ds.

(Signed) J. L. Reynolds M. D.
3/6/1920 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 4/1 1920

20. UNDERTAKER: C. A. Buckmun
ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29651

Registered No.

1. PLACE OF DEATH.
County of Valley
City of
(No. , St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Frank Van Atta

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Not Known

6. DATE OF BIRTH: Not Known (Month) (Day) 1 (Year)

7. AGE: 45 yrs. mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profesSsion, or particular kind of work: Lumberman
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Known

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): G. E. Noggle
(Address): Emmett Ida

15.
Filed Apr 7 1920 J. A. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1911, to 1911, that I last saw h alive on 1911, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Heart failure

(Duration) Not Known yrs. mos. ds.
Contributory (Secondary): Not Known
(Duration) yrs. mos. ds.

(Signed) G. E. Noggle, M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida
DATE OF BURIAL: 4/7 1920

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29652

Registration District No. 1694
Primary Registration District No.
(No. ..... St.)
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clemm Dunn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Apr (Month) 22 (Day) 1895 (Year)

7. AGE: 23 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroad Brakeman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: E G. Dunn

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mattie Wyant

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C Dunn
(Address) Payette Ida

15. Filed 3/13 1920 J L Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from At time of death Mar 9 1920
that I last saw h... alive on Mar 7 1920
and that death occurred on the date stated above, at 1.45 P.M.
The CAUSE OF DEATH* was as follows: Railroad accident

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): none
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J L Reynolds M. D.
3/10 1920 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida
DATE OF BURIAL: 3/11 1920

20. UNDERTAKER: C L Bucknum
ADDRESS: Emmett Idaho

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29653
Registered No.

1. PLACE OF DEATH.
County of Gem
City of Emmett
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. 10 7d

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Anna Schlund

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... 1 ..... (Month) (Day) (Year)

7. AGE: 43 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Joseph Burger

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Casper Schlund
(Address) Emmett Idaho

15.
Filed 3/25 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 18 1920, to ..... 191..
that I last saw her alive on March 18 1920,
and that death occurred on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:
She died within 30 minutes after I arrived, acute dyspnoea & heart failure. I could not determine cause.
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Probably a ford poisoning causing acute nephritis etc.
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. P. McCalla M. D.
3/20 1920 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: ..... 191..

20. UNDERTAKER: O. D. Bucknum
ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29654

Registered No.

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10 W
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Martha M. Mitchell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	widow

6. DATE OF BIRTH Sept (Month) 26 (Day) 1838 (Year)

7. AGE 81 yrs. 5 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER John Thompson

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Sheppard
(Address) Baker City Oregon

15.
Filed Apr 7 1920 J. D. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/10 1920, to 3/17 1920
that I last saw her alive on 3/17 1920
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
Cerebral thrombosis
(Duration) yrs. mos. 10 ds.
Contributory (Secondary) Arterio sclerosis
(Duration) Several yrs. mos. ds.
(Signed) R. N. Cummings M. D.
3/27 1920 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL Emmett Ida | DATE OF BURIAL Mar 23 1920

20. UNDERTAKER R. Buckmaster | ADDRESS Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29655

Registered No.

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1021

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samantha J. Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: June (Month) 25 (Day) 1857 (Year)

7. AGE: 62 Yrs. 8 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Abraham Fretz

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Martha Gillie

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. E. Phillips
(Address) Emmett Idaho

15. Filed Mar 17 1920 — J. L. Reynolds, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10th 1920, to Mar 15th 1920, that I last saw h[er] alive on Mar 14th 1920, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Martin A. Byrd M. D.

3/16 1920 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and. (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fruita, Col. — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: D. Bucknum — ADDRESS Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1020
Primary Registration District No.
File No. 29656
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Lewis Rolland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: July (Month) 3 (Day) 1918 (Year)

7. AGE: 1 Yrs. 8 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Albert Rolland

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Etta Grey

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Rolland
(Address) Emmett Idaho

15. Filed 3/15 1920 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1920, to Mar 6 1920, that I last saw him alive on Mar 6 1920, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Broncho Pneumonia
(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 4 ds.

(Signed) J. L. Reynolds M. D.
3/15 1920 (Address) J. L. Reynolds

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 3/7 1920
20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29657
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1924
Primary Registration District No.

2. FULL NAME Harry G. Lansing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH
May 22 1875
(Month) (Day) (Year)

7. AGE
44 Yrs. 9 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER A. G. Lansing

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Elizabeth Jones

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Lansing
(Address)

15. Filed 3/15 1921 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920 to Mar 12 1920 that I last saw h.... alive on Mar 10 1920 and that death occurred on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:
Valvular heart disease
Mitral lesion
(Duration) Several Yrs. ..... mos. ..... ds.
Contributory (Secondary) Rheumatism
(Duration) several yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.
3/15 1920 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	3/14 1920
20. UNDERTAKER	**ADDRESS**
C. L. Bucknum	Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 29658
Registered No. 13

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Herman Castle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Dec. (Month) 27 (Day) 1894 (Year)
7. AGE: 25 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Nodl Missouri
10. NAME OF FATHER: Frank Heath
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER: Laura Kirk
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ben Castle
(Address) Grangeville
15. Filed April 1 1920 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920, to Feb 22nd 1920, that I last saw her alive on Feb 22nd 1920, and that death occured on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:
Burns over about one-half of body. Caused by Gasoline Explosion
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) B Chipman M. D.
2/24 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Denver — DATE OF BURIAL: Feb 25th 1920
20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

6YMB - YORK CO., PTRS. & SONS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 29659
Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ida
City of Dubois

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecil Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
April (Month) 14 (Day) 1903 (Year)

7. AGE
16 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James I Johnson

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Hanna Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James I Johnson
(Address) Dubois Ida

15.
Filed April 8 1920
G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 16 1920, to March 18 1920, that I last saw h.im alive on March 17 1920, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation of heart

(Duration) 1 Yrs. 4 mos. ds.
Contributory (Secondary) Rheumatism, Flu,
(Duration) 2 yrs. 4 mos. ds.
(Signed) G S Stockton M. D.
3/19 1920 (Address) Evanston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hopewell Cemetery
DATE OF BURIAL: Mar 21 1920

20. UNDERTAKER: A L Maugg
ADDRESS: Evanston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 29660
Registered No. 13

1. PLACE OF DEATH.
County of Ida
City of Grangeville (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katharina Von Berg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH. April 21 (Month) (Day) 1860 (Year)

7. AGE: 59 Yrs. 11 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Emil Von Berg
(Address) Grangeville

15.
Filed April 8 1920 — G S Stockton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 31 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1919, to March 31 1920, that I last saw her alive on March 29 1920 and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) Several Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.
4/8 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverview — DATE OF BURIAL: April 3 1920

20. UNDERTAKER: J Mauzy — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29661

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Idaho

City of White Bird (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Milton Hadorn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 23 (Day) 1866 (Year)

7. AGE: 33 yrs. 1 mos. 8 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dear Creek Idaho

10. NAME OF FATHER: John Hadorn

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Virginia Galloway

13. BIRTHPLACE OF MOTHER (State or Country): Mississippi

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S S Galloway
(Address) White Bird

15. Filed 191 W. A. Foskett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 23 1920, to Jan 31 1920, that I last saw him alive on Jan 31 1920, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia fulminant influenza

(Duration) yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W A Foskett M. D.

Feb 2 1920 (Address) White Bird Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: White Bird

DATE OF BURIAL: Feb 2d 1920

20. UNDERTAKER: E S Hancock

ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Idaho

City of Joseph

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

File No. 129662

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gideon Unzicker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. January (Month) 13 (Day) 1856 (Year)

7. AGE: 63 Yrs. 3 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: John S Unzicker

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Mary Miller

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. W. Blake

(Address) Col Townsend Ida

15.

Filed April 14 1920

W B Blake
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ investigated the facts of the death of deceased ~~from~~ On the 14th day of April 1920, to ~~191~~, that ~~I last saw h~~ alive on ~~191~~, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W B Blake M. D.

1920 (Address) Register District 105

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Marsantown — DATE OF BURIAL: 4-15 1920

20. UNDERTAKER: O A Ran — ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 29663
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Orres

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 21 (Day) 1858 (Year)

7. AGE: 61 Yrs. 11 Mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Butcher Orres

11. BIRTHPLACE OF FATHER (State or Country) Not Known (U.S)

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harvey Orris
(Address) Cottonwood Idaho

15. Filed April 21 1920 H B Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1920, to April 20 1920, that I last saw him alive on April 18 1920 and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Steinicke M. D.
4-21 1920 (Address) Cottonwood Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver
DATE OF BURIAL: 4-22 1920

20. UNDERTAKER: W A Nau
ADDRESS: Cottonwood

SYMS - YORK CO., PTRS. & ENGRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of IDAHO

City of COTTONWOOD

Registration District No. 105

Primary Registration District No. 2183

(No. .... St.)

File No. 129664

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME MARY LENORE KAUFMANN.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: FEMALE

4. COLOR OR RACE: WHITE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): SINGLE

6. DATE OF BIRTH. ~~20~~ NOV. (Month) 23 (Day) 1919 (Year)

7. AGE: ..... Yrs. 5 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): IDAHO.

10. NAME OF FATHER: JOSEPH F. KAUFFMAN.

11. BIRTHPLACE OF FATHER (State or Country): ILL.

12. MAIDEN NAME OF MOTHER: ~~REDMOND, POISSON.~~

13. BIRTHPLACE OF MOTHER (State or Country): MONT.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph F. Kaufmann

(Address) Cottonwood Idaho

15. Filed April 27 1920

H. W. Blake
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1920, to April 25 1920, that I last saw h[illegible] alive on April 25 1920 and that death occured on the date stated above, at 6.45 A.M.

The CAUSE OF DEATH* was as follows: 6.45 am

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) Prematurity

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.

4/27 1920 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood — DATE OF BURIAL: 4-27 1920

20. UNDERTAKER: [illegible] — ADDRESS: Cottonwood Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 29666
Registered No. 88

1. PLACE OF DEATH.
County of Idaho
City of Kooskia (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johnson Spencer
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Indian	Single

6. DATE OF BIRTH
February 13 1919
(Month) (Day) (Year)

7. AGE
1 yrs. ..... mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Johnson Spencer

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Mary Penny

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johnson Spencer
(Address) Kooskia - Idaho

15.
Filed March 14 1920 J M Weberkuers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 29 1920 to March 12 1920
that I last saw him alive on March 9 1920
and that death occurred on the date stated above, at 4 45 A.M.

The CAUSE OF DEATH* was as follows:
Tubercular Meningitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Weberkuers M. D.
March 20 1920 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Cemetery Kooskia
DATE OF BURIAL: March 15 1920

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 29667
Registered No. 89

1. PLACE OF DEATH.
County of Idaho
City of Kooskia
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ole A. Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Jan. (Month) 1 (Day) 1842 (Year)

7. AGE: 78 Yrs. 2 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Peter Johnson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Earl Peterson
(Address) Kooskia

15.
Filed March 18 1920
J. M. Herbert Knox
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: -
No medical attendance.
Death due probably to-
Chronic Endocarditis.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Herbert Knox M. D.
March 19 20 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Willow Hill Cemetery. DATE OF BURIAL: March 18 1920

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
File No. 29670
(No. 2 St.)
Registered No. 54

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John R Tatum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Mar (Day) 25 (Year) 1894

7. AGE: 25 Yrs. 11 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Edward P. Tatum

11. BIRTHPLACE OF FATHER (State or Country): Ga.

12. MAIDEN NAME OF MOTHER: Molly M Calaway

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. H. Tatum
(Address) Black Lake Ida

15. Filed April 1 1920 M. M. Strong Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Mar (Day) 2 (Year) 1920

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920, to Mar 2 1920, that I last saw h— alive on Mar 2 1920 and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Timmons M. D.
3-3 1920 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harrison — DATE OF BURIAL: Mar. 4 1920

20. UNDERTAKER: Gus Nelson — ADDRESS: Coeur d'Alene

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29671

Registered No. 15

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene (No. 917 Lakeside St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

2. FULL NAME Emeline Pauly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 4 (Day) 1842 (Year)

7. AGE: 77 Yrs. 11 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Prentiss B. Reed

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Elizabeth

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R A Pauly
(Address) Coeur d. Alene Idaho

15. Filed Mar 5 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 16 1920, to Mch 2 1920, that I last saw h alive on Feb. 27 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arteriosclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J C Weyer M. D.

Mch 3 1920 (Address) Coeur d Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene — DATE OF BURIAL: 3-5 1920

20. UNDERTAKER: C. Cassidy — ADDRESS: CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 25672

Registered No. 20

1. PLACE OF DEATH.

County of Kootenai

Registration District No. 29

Primary Registration District No. 1050

City of Coeur d'Alene (No. 615 Sherman St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Millerand Sorenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. 3 (Month) 21 (Day) 1920 (Year)

7. AGE ..... Yrs. 16 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER S. M. Sorenson

11. BIRTHPLACE OF FATHER (State or Country) Minn.

12. MAIDEN NAME OF MOTHER May Anna Morris

13. BIRTHPLACE OF MOTHER (State or Country) S. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) S. M. Sorenson

(Address) .....

15. Filed April 8 1920 Gus Nilsen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 6th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920, to April 6 1920, that I last saw h[illegible] alive on April 6 1920, and that death occured on the date stated above, at 10:00 P M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis, Causing Uremia.

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Bronchial Pneumonia

(Duration ..... yrs. ..... mos. 10 ds.

(Signed) J. H. Forbes M. D.

4/8 1920 (Address) Coeur D'Alene Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. C'D'Alene — DATE OF BURIAL: 4-8 1920

20. UNDERTAKER: C. Cassady — ADDRESS: C'D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 29673
Registered No. 19

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. 822 Riverside St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie LaFountain

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. April (Month) 1 (Day) 1920 (Year)

7. AGE: ....Yrs. ....Mos. 3 ....ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. L. LaFountain

11. BIRTHPLACE OF FATHER (State or Country) Mich.

12. MAIDEN NAME OF MOTHER Laura Legault

13. BIRTHPLACE OF MOTHER (State or Country) Montreal.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. La Fontaine
(Address) ....

15. Filed April 4 1920 Gus Nelson Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920, to April 3 1920, that I last saw her alive on April 3 1920, and that death occured on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:
premature infant of about 6½ months in utero

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) ....
(Duration ....yrs. ....mos. ....ds.

(Signed) Louis N. Mosk M. D.
April 4 1920 (Address) Coeur d' Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: St. Thomas. C D Alene — DATE OF BURIAL: 4-5- 1920

20. UNDERTAKER: C Cassedy — ADDRESS: C D Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29674

Registered No. 18

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene. (No. ....., ... St.)

Registration District No. 29

Primary Registration District No. 1050

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman Lawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. May (Month) 11 (Day) 1839 (Year)

7. AGE: 80 Yrs. 10 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Lawson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) M. Rt. Lawson

15. Filed Mch. 24 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 27 1920, to Mch 22 1920, that I last saw h in alive on Mch 21 1920, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) — Yrs. — mos. 20 ds.

Contributory (Secondary) —

..... (Duration — yrs. — mos. — ds.

(Signed) W. H. Hoeldeke M. D.

3/23 1920 (Address) Coeur d'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. C. D'Alene

DATE OF BURIAL: 3-24 1920

20. UNDERTAKER: C. Cassedy

ADDRESS: C D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 23675

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 1050

(No. C d A Hospital St.)

2. FULL NAME Geo Costello

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Apr 30 1897 (Month) (Day) (Year)

7. AGE: 22 Yrs. 4 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mill worker

(b) General nature of industry, business or establishment in which employed (or employer): Rockwell Lumber Co

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Joseph Costello

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Elizabeth Eugenette

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jeanette Costello

(Address) Coeur d'Alene

15. Filed March 26 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 23 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1920 to March 23 1920 that I last saw h[illegible] alive on March 23 1920 and that death occurred on the date stated above, at 10.40 P.M.

The CAUSE OF DEATH* was as follows:

Accidental injury saw mill

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Alexander Barclay M. D.

3-25 1920 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 hours days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 3/26 1920

20. UNDERTAKER: C B Mooney — ADDRESS: C d A Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1037
File No. 29676
Registered No. 17

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. Coeur d'Alene Hosp St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis F Guthery
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec 28 1879 (Month) (Day) (Year)

7. AGE: 40 Yrs. 3 Mos. 19 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mill worker
(b) General nature of industry, business or establishment in which employed (or employer): Blackwell Lumber Co

9. BIRTHPLACE (State or Country): Ark.

10. NAME OF FATHER: Louis Guthery

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Sara Clark

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lillie A Guthery
(Address) Coeur d Alene Idaho

15. Filed Mch 20 1920 Gus Nelson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 17 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1920 to March 17 1920 that I last saw h Um alive on March 17 1920 and that death occurred on the date stated above, at 4 A M.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) 0 Yrs. 0 mos. 7 ds.
Contributory (Secondary) Pericarditis
(Duration) 0 yrs. 0 mos. 7 ds.

(Signed) Alexander Davlan M. D.
3-19 1920 (Address) Coeur d Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 1 days. In the State.....yrs. 9 mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 3/19 1920
20. UNDERTAKER: R & D Doney — ADDRESS: Cda Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29677

Registered No. 16

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1052

(No. C d A Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME German Sanganeos

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write word.)

6. DATE OF BIRTH: Unknown (Month) (Day) (Year)

7. AGE: About 30 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mill Worker

(b) General nature of industry, business or establishment in which employed (or employer): Blackwell Lumber Co

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Coeur d'Alene Hospital

(Address) Coeur d'Alene

15. Filed March 16 1920 Gus Nelson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 3 1920, to March 8 1920, that I last saw h.m. alive on March 8 1920, and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary) Pulmonic endocarditis

(Duration) Several yrs. mos. ds.

(Signed) Alexander Barclay M. D.

3-10 1920 (Address) Coeur d'Alene

*State the Disease Causing Death; or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 6 days. In the State yrs. / mos. days

Where was disease contracted if not at place of death?

Former or usual residence Sand Point Ida

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 3/13 1920

20. UNDERTAKER: P B Mooney — ADDRESS: C d A. Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 7-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29678
Registered No. 697

1. PLACE OF DEATH
Registration District No.
County of Lewis
Primary Registration District No.
City of Lewiston No. Emergency St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harold Bro

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write one word.): Single

6. DATE OF BIRTH: Aug (Month) 23 (Day) 19 17 (Year)

7. AGE: 2 Yrs. 5 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Floyd Bro

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Minnie Klinkie

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Floyd Bro
(Address) Yakima Wn

15.
Filed 3-10 1920 G. D. Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920, to Feb 22 1920
that I last saw h[im] alive on Feb 21 1920,
and that death occurred on the date stated above, at 2 A M.
The CAUSE OF DEATH* was as follows:
Double pneumonia

(Duration) ... Yrs. ... mos. 7 ds.
Contributory (Secondary) Influenza
(Duration) ... yrs. ... mos. 10 ds.

(Signed) W. H. Hoeden M. D.
2/23 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. 6 mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Thomas Cem	2/24 1920
20. UNDERTAKER	ADDRESS
R. G. Mooney	Lew

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1087
File No. 29678
Registered No. 678

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. Emergency Hosp St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Olsen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April 5 1878 (Month) (Day) (Year)

7. AGE: 40 Yrs. 10 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Rudolph Miller

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Clara Bay

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J H Miller
(Address) Amber Mon

15. Filed 3-10 1920 D. D. Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 16 1920, to Mch 2 1920, that I last saw h. alive on Mch 2 1920 and that death occurred on the date stated above, at 1 A M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) Influenza
(Duration) Yrs. mos. 8 ds.

(Signed) J. O. Dwyer M. D.
Mch 2 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 20 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 1920

20. UNDERTAKER: J. O. Dwyer | ADDRESS Cda Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30

Primary Registration District No. 1051 & 2057

File No. 29680

Registered No. 7

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillie Zornes Zorn[illegible]

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	M

6. DATE OF BIRTH. Feb (Month) 26 (Day) 1896 (Year)

7. AGE 24 Yrs. 2[illegible] Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER David R Berry

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Rebecca E Yates

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs M. W. Zornes

(Address) Rathdrum Ida

15.

Filed 4/1. 192[illegible]. Frank Mann Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Febry 29th

Feb (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febry 22. 1920, to Febry 29 1920, that I last saw h[illegible] alive on Febry 29 1920, and that death occured on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia
and Epidemic Influenza

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Miscarriage at 6 mos

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Frank Mann M. D.

3/1. 1920 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rathdrum Cemetary DATE OF BURIAL March 3 191[illegible]

20. UNDERTAKER C. W. Edens ADDRESS Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 10516 7051
(No Kootenai County Hospital St.)

File No. 29081
Registered No. 8

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charley Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1862 (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Liberty Morris Sr.
(Address) Rathdrum Idaho

15. Filed 4/1. 1920 Frank Perry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1919, to March 2. 1920, that I last saw h... alive on March 2. 1920, and that death occured on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Cirrhosis of liver
(Duration) about 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Frank Perry M. D.
3/2. 1920 (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. 3 mos. 5 days. In the State 5 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Post Falls, Ida.
Former or usual residence Post Falls, Idaho

19. PLACE OF BURIAL OR REMOVAL: Co Plaffs Rathdrum Ida. DATE OF BURIAL: March 5 1920
20. UNDERTAKER: C. W. Glover ADDRESS: Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 29682
Registered No. 706

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 4 Lennane ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles D Farmer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: July (Month) 8 (Day) 40 (Year)

7. AGE: 79 Yrs. 6 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): U S Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J P Lewis
(Address) Coeur d'Alene

15. Filed April 2 1920 D. D. Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to Mch 27 1920 that I last saw h.. alive on " 27 1920 and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Senile decay

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D D Drennan M. D.

3/27 1920 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State 58 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fort Cemetery — DATE OF BURIAL: 3/28 1920

20. UNDERTAKER: R H Doody — ADDRESS: C. d'A.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 2051
File No. 25083
Registered No. 703

1. PLACE OF DEATH
County of Kootenai
City of Post Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eveline Nogle
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 2 (Day) 1861 (Year)

7. AGE: 58 Yrs. 3 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.? —

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Jazo Bumpo

11. BIRTHPLACE OF FATHER (State or Country): N York

12. MAIDEN NAME OF MOTHER: Caroline Cathcart

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Nogle
(Address) Post Falls Ida

15. Filed April 2 1920 L. D. Dressman, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1919 to Feb 23 1920 that I last saw h[illegible] alive on Feb 22 1920 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Cancer of Bowel
(Carcinoma of Intestines)
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. L. McCauley M. D.
2/24 1920 (Address) Post Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 30 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Post Falls	2/24 1920
20. UNDERTAKER R B Mooney	ADDRESS Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 2057
(No. ....., ... St.)

File No. 29684
Registered No. 704

1. PLACE OF DEATH
County of Bonneville
City of Post Falls
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Peters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: Feb (Month) 19th (Day) 1920 (Year)
7. AGE: 0 Yrs. 1 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Chas A Peters
11. BIRTHPLACE OF FATHER (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Victoria Clete
13. BIRTHPLACE OF MOTHER (State or Country): Mo
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas A Peters
(Address) Post Falls Ida
15. Filed April 2 1920 O D Drennen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 24 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 19 1920 to Mar. 24 1920 that I last saw h.. alive on Mar. 24 1920 and that death occurred on the date stated above, at 10a.M.
The CAUSE OF DEATH* was as follows:
(Influenza)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) acute Indigestion
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. L. McCauley M. D.
3/25 1920 (Address) Post Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. 1 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls Ida — DATE OF BURIAL: Mch 25 1920
20. UNDERTAKER: [signature] — ADDRESS: Coeur d'Alene

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29685

Registered No. 703

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

(No. ....., ..., St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 2051

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anton Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH: April (Month) 24 (Day) 1863 (Year)

7. AGE: 56 Yrs. 10 Mos. 1 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Timber Worker
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Sven Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Svenson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sam Anderson
(Address) Clinton Wis.

15. Filed April 2, 1920 D. D. Williamson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH* was as follows:
Man was found dead, he with other men was working in a lumber camp. He stopped once to have a bowel movement and fell over dead.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) No autopsy - No inquest - was about 6 hours since attack
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Frank Young, Reg. M. D.
2/2 1920 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clinton Wis. DATE OF BURIAL: Feb. 27 1920

20. UNDERTAKER: A. W. Storm ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
(No. ..... St.)

File No. 29686
Registered No. 702

1. PLACE OF DEATH.
County of Kootenai
City, of Ford -
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosamond McClennon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 2 (Day) 1882 (Year)

7. AGE: 38 Yrs. 2 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife -
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Saginaw County Mich.

10. NAME OF FATHER: Ralph Sisswold -

11. BIRTHPLACE OF FATHER (State or Country): Conn -

12. MAIDEN NAME OF MOTHER: Katrina Kulp -

13. BIRTHPLACE OF MOTHER (State or Country): Canada -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Aleck McClennon
(Address) Setters, Ida.

15. Filed April 2 1920 D. D. Drennen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to March 15 1920, that I last saw her alive on March 15 1920, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) I. H. Thurston, M. D.
3/23 1920 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. ..... mos. ..... days. In the State 2 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Canada -

19. PLACE OF BURIAL OR REMOVAL: Mica Cemetary — DATE OF BURIAL: 3/19 1920

20. UNDERTAKER: None - — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1054
File No. 29687
Registered No. 701

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 1111, North 4th St.)
If death occurs away from usual residence give facts called for under special information.

2. FULL NAME Peride Lecaux

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January (Month) 22 (Day) 1898 (Year)

7. AGE: 22 Yrs. 2 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Maker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colo

10. NAME OF FATHER: Samuel Tranby

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Lecaux
(Address) Coeur d'Alene

15. Filed April 2. 1920. H. D. Drummer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1920, to March 13 1920, that I last saw h[er] alive on March 13 1920, and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia following Influenza

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) influenza
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Hoedemaker M. D.
3/15 1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 4 yrs. 6 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery | DATE OF BURIAL: March 16 1920
20. UNDERTAKER: [illegible] | ADDRESS: Cda Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 29688
Registered No. 700

1. PLACE OF DEATH
County of Kootenai
City of Square Bay
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sapiet Morgan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) ..... (Day) 1919 (Year)

7. AGE: ~~11~~ Yrs. 11 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ~~~~
(b) General nature of industry, business or establishment in which employed (or employer): ~~~~

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Joseph Morgan

11. BIRTHPLACE OF FATHER (State or Country): Kas.

12. MAIDEN NAME OF MOTHER: Sophia Bolly

13. BIRTHPLACE OF MOTHER (State or Country): Nebr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Morgan
(Address) Council Adams

15. Filed April 2, 1919. W. W. Brennen Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch 7 (Month) ..... (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ was attended deceased from ~~~~ 19..... to ~~~~ 19.....
that I last saw h~~~~ alive on ~~~~ 19.....
and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Child found dead in bed. Seemed to have
a fit and died suddenly. Contributory cause
unknown.
..... (Duration) ..... Yrs. ~~~~ mos. ~~~~ ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. T. Kramer M. D.
3/9 1920 (Address) Council Adams Co.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 3/9 1920

20. UNDERTAKER: P. J. Mooney — ADDRESS: Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 29691
Registered No. 93

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosa Grieser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 3 (Day) 1896 (Year)

7. AGE: 26 Yrs. 6 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Grieser

11. BIRTHPLACE OF FATHER (State or Country): Louisiana

12. MAIDEN NAME OF MOTHER: Katie Gillman

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Grieser
(Address) Moscow Idaho

15. Filed 3/2 1920 N.H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 26 - 1920, to Mch 1 1920
that I last saw h[illegible] alive on Mch 1 1920
and that death occurred on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:

Pyemia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Charles L. Gritman M. D.
3/2 1920 (Address) Moscow Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. In the State ..... yrs. ..... mos. 5 days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee Idaho
DATE OF BURIAL: 3/3 1920

20. UNDERTAKER: Glen Price
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29692

Registered No. 91

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. 123 E Ashburg St.)

2. FULL NAME Sarah South.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 11 (Day) 1864 (Year)

7. AGE: 55 Yrs. 6 Mos. 23 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmers wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John McGee

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Kit Rhinehart

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. South

(Address) Moscow

15. Filed Mch 6 1920 W. H. Saithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1919 to Mar. 3, 1920, that I last saw her alive on Mar. 3, 1920, and that death occurred on the date stated above, at 12 20 M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wilt M. D.

Mch 6 1920 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 3/7 1920

20. UNDERTAKER: Glen Hill — ADDRESS: Moscow

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6)
Primary Registration District No. 1011
(No. ..... , ... St.)
File No. 29095
Registered No. 90

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Albert Nifong
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 10 (Day) 1866 (Year)

7. AGE: 53 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: James Nifong

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Mary Le Fleur

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Nifong
(Address) Moscow

15. Filed 3/19 1920 W. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17th 1920, to March 17th 1920 that I last saw him alive on March 17th 1920 and that death occurred on the date stated above, at 10-15 P.M.

The CAUSE OF DEATH* was as follows:
Brights Disease

(Duration) 4 Yrs. - mos. - ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Harrington M. D.
3/19 1920 (Address) Moscow, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: Mar 20 1920

20. UNDERTAKER: Gilbert Price | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... St.)

File No. 29694
Registered No. 89

1. PLACE OF DEATH
County of Latah.
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Nathaniel Phillips
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Oct (Month) 16th (Day) 1827 (Year)

7. AGE: 92 Yrs. 5 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Pliny Linneas Phillips.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Fidelia Hall.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs D. Chamberlain
(Address) Moscow Idaho

15. Filed 3/30 1920 W. A. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/12 1920, to 3/25 1920 that I last saw h[illegible] alive on 3/27 1920 and that death occurred on the date stated above, at 7 10 A.M.
The CAUSE OF DEATH* was as follows:

Old age - Prostatitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Canfield & Co. M. D.
3/30 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Alcester So Dakota | DATE OF BURIAL 1920

20. UNDERTAKER: Glen Grice | ADDRESS Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 2141
(No. County Home St.)
2. FULL NAME William B. Turner

File No. 29695
Registered No. 92
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED or DIVORCED (Write the word.): Not Known

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1861 (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not Known Here

10. NAME OF FATHER: " " "

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Meek
(Address) Co Home, Moscow

15. Filed 3/7 1920 N. H. Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 6 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1st 1919 to Mar 6th 1920 that I last saw him alive on Mar 6th 1920 and that death occurred on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Larynx
(Duration) 5 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Hearnsan M. D.
3/7 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Georgetown Texas

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 3/7 1920

20. UNDERTAKER: Gleed Bros. | ADDRESS: Moscow

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2143
File No. 29696
Registered No. 6

1. PLACE OF DEATH.
County of Latah
City of Genesee
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martin Baumgartner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Sept 20 (Month) (Day) 1874 (Year)

7. AGE: 90 Yrs. 5 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Logger
(b) General nature of industry, business, or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Jno. Baumgartner

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Christena Gruber Baumgartner

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Matt Baumgartner
(Address) Genesee Idaho

15. Filed 3-17th 1920 W. T. Eblen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11 1920, to March 11 1920, that I last saw h— alive on March 11 1920, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pleuro Endocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Uremic Poisoning

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Eblen M. D.
3-16 1920 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee Mo — DATE OF BURIAL: 3-20 1920

20. UNDERTAKER: Lambert — ADDRESS: Genesee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 29697
Registered No.

1. PLACE OF DEATH
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isabell Maxine Reed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Dec (Month) 24 (Day) 1895 (Year)

7. AGE: 22 Yrs. 3 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: David C Funk

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Anna Brogan

13. BIRTHPLACE OF MOTHER (State or Country): Poland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herbert Reed
(Address) Troy Idaho

15. Filed Mar 27 1920 J E Pickerd Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Gun-shot Wound Chest
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Allen Greer Coroner M. D.
3/22/20 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho | DATE OF BURIAL: Mar 29 1920

20. UNDERTAKER: J E Pickerd | ADDRESS: Troy

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29698
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65
Primary Registration District No. 2145
(No. .... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Virgil Israel Jennings

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Feb. (Month) 3 (Day) 1920 (Year)

7. AGE. ... Yrs. 1 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Onaway Latah Co, Ida

10. NAME OF FATHER Robert H. Jennings

11. BIRTHPLACE OF FATHER (State or Country) Wash.

12. MAIDEN NAME OF MOTHER Mabel O. Bryan

13. BIRTHPLACE OF MOTHER (State or Country) Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) father.
(Address) Potlatch Ida

15. Filed Feb. 5th 1920 D. Jr. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1920, to March 9 1920, that I last saw him alive on March 9. 1920, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) none

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest Stein M. D.

3/9/1920 (Address) Potlatch Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: Feb. 5 1920

20. UNDERTAKER: Parents. — ADDRESS: Potlatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29699
Registered No.

1. PLACE OF DEATH.
County of Latah
City of
(No. , St.)

Registration District No. 65
Primary Registration District No. 2145

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leslie Louis Walker.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH March 19 1920
(Month) (Day) (Year)

7. AGE
no yrs. no mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Latah Co

10. NAME OF FATHER Fay E Walker

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Engine Severson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) father
(Address) Pullman

15.
Filed April 7 1920 D.W.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April 6 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~~ 191 to ~~~ 191
that I last saw him alive on April 6 1920
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) — yrs. — mos. 2 ds.
Contributory (Secondary) none
(Duration) — yrs. — mos. — ds.

(Signed) Ernest S Hein M. D.
19 (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow Cemetery	April 7 1920
20. UNDERTAKER	ADDRESS
Barnes.	Potlatch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 29700
Registered No. 26

1. PLACE OF DEATH.
County of Latah
City of Deary P.O. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edmund A. Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Sept. 11 (Month) (Day) 1838 (Year)

7. AGE: 81 yrs. 5 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N.Y.

10. NAME OF FATHER: Wm Wright

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Sara Allen

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Laura M. Moore
(Address) Deary R.1

15. Filed 3-1 1920 Pl. Faust Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. 1 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10 1920, to Feb. 17 1920, that I last saw h[illegible] alive on Feb. 17 1920, and that death occurred on the date stated above, at 12.45 M.

The CAUSE OF DEATH* was as follows: Heart Failure

(Duration) — yrs. 1 mos. — ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) Pl. Faust M. D.
3/1 1920 (Address) Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elwood Cem. | DATE OF BURIAL: 3-3 1920

20. UNDERTAKER: ~ | ADDRESS: ~

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29702
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Kendrick
(No. ..... St.)
Registration District No. 68
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Peter DeFord

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH: Sept (Month) 10 (Day) 1837 (Year)
7. AGE: 82 yrs. 5 mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer.
(b) General nature of industry business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Potsdam Co. N. Y.
10. NAME OF FATHER: Peter DeFord.
11. BIRTHPLACE OF FATHER (State or Country): Ottawa Canada
12. MAIDEN NAME OF MOTHER: Do not know
13. BIRTHPLACE OF MOTHER (State or Country): Do not know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira Tolon
(Address) Kendrick Ida
15. Filed 3-26 1920 R. P. Pepple Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 26 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 24 1920, to Mar 26 1920, that I last saw h— alive on Friday Mar 26 1920 and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
Myocarditis
(Duration) 4 yrs. mos. ds.
Contributory (Secondary) x
(Duration) x yrs. x mos. x ds.
(Signed) J. R. Tuller M. D.
19 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ REMOVAL: Lewiston Ida
DATE OF BURIAL: 3/26 1920
20. UNDERTAKER: E E Beckstol
ADDRESS: Kendrick Idaho

Julia Ida

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29703
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Kendrick

Registration District No. 68
Primary Registration District No.
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Andrew Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Aug (Month) 20th (Day) 1852 (Year)
7. AGE: 68 yrs. 7 mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): New York State
10. NAME OF FATHER: Andrew John Hill
11. BIRTHPLACE OF FATHER (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Scotland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John M. Hill
(Address) Kendrick Idaho
15.
Filed 3-21 1920 R. T. Pepper Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar. (Month) 20th (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1915, to Mar. 20th 1920
that I last saw him alive on Mar 19th 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Chronic Bright's Disease
(Duration) 1 yrs. — mos. — ds.
Contributory (Secondary) Valvular insufficiency of heart
(Duration) 10 yrs. — mos. — ds.
(Signed) W. E. Rothwell M. D.
Mar 21. 1920 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kendrick Idaho
DATE OF BURIAL: Mar 22 1920
20. UNDERTAKER: Edmon Bechtol
ADDRESS: Kendrick Idaho

Juliaetta Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29704

Registration District No. 41
Primary Registration District No. 2116

1. PLACE OF DEATH
County of Lemhi
City of Salmon
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudolph H. Schanfelberger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 8 (Day) 1883 (Year)

7. AGE: 36 Yrs. 11 Mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Rudolph Schanfelberger

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Not Known.

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benson Evans
(Address) Salmon Ida

15. Filed 4/10 1920 M. Deming Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 28th (Day) 1920 (Year).

17. I HEREBY CERTIFY, That I attended deceased from Mar. 27th 1920, to March 28 1920 that I last saw him alive on March 28 1920 and that death occurred on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH was as follows:*
Broncho Pneumonia
complicating Influenza
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. Stratton M. D.
3/29 1920 (Address) Salmon, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE ~~OF BURIAL~~ OR REMOVAL: Boise Idaho
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Wm C Jacobs
ADDRESS: Salmon Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29706

Registered No. 10

1. PLACE OF DEATH.

County of Lewis

City of Ko

Registration District No. 30

Primary Registration District No. 2129.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Andrew Glenn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Feb (Month) 28 (Day) 96 (Year)

7. AGE: 4 Yrs. ..... Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida Idaho.

10. NAME OF FATHER: Andrew Maxwell Glenn

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Lilly Wright

13. BIRTHPLACE OF MOTHER (State or Country): Dayton Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A M Johnson

(Address) Ko Idaho

15. Filed 3/26 1920 P E Durham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1920, to March 25 1920, that I last saw h[er] alive on March 25 1920, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Atelectasis Pneumonia

1 1/2 days

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza Pneumonia 3 days

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) P E Durham M. D.

3/26 1920 (Address) Ko Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ko Cemetery — DATE OF BURIAL: 3/26 1920

20. UNDERTAKER: Ko Undertaking — ADDRESS: Ko.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

over

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 21 7
(No. ..... St.)

File No. 29709
Registered No. .....

1. PLACE OF DEATH.
County of Lewis
City of Kamiah

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Hawkins

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 27th (Day) 1851 (Year)

7. AGE: 68 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Albert Hawkins

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Laura B. Hawkins
(Address) Kamiah Idaho

15. Filed 4/28 19[illegible]

C. J. Johnson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March (Month) 28 (Day) 19[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible] 19[illegible], to Christ 191..., that I last saw h[illegible] alive on Feb. 10th 19[illegible], and that death occured on the date stated above, at 4.45 A.M.

The CAUSE OF DEATH* was as follows:
Chronic nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
4/4 19[illegible] (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Foot Cem. Kamiah Idaho
DATE OF BURIAL: 4/29 19[illegible]

20. UNDERTAKER: C. J. Johnson
ADDRESS: Kamiah Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2016
(No. .... St.)

File No. 29711
Registered No. 15

1. PLACE OF DEATH.
County of Lemhi
City of Dietrich
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Freda Huse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. March (Month) 30 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ludwig Huse

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Augusta Lehman

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C P Jones
(Address) Shoshone

15. Filed Apr 6 1920
J K Fuller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Apr 2 1920, to ..... 191..., that I last saw her alive on Apr 2 1920, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Jaundice neonatorum
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C P Jones M. D.
19..... (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 4/7 1920

20. UNDERTAKER: Ludwig Huse — ADDRESS: Dietrich

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1010
File No. 29712
Registered No. 14

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cornelius Hubbs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Nov 25 1880
(Month) (Day) (Year)

7. AGE: 39 yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Cornelius Hubbs

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Charlotte Jamison

13. BIRTHPLACE OF MOTHER (State or Country): Penn'a

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert Hubbs
(Address) Shoshone

15. Filed April 5" 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1920, to April 4 1920, that I last saw him alive on April 4 1920, and that death occured on the date stated above, at P M.

The CAUSE OF DEATH* was as follows:
Acute infectious Cholecystitis

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C P Jones M. D.
19 ..... (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone Idaho — DATE OF BURIAL: 191

20. UNDERTAKER: O J Barman — ADDRESS: Shoshone

BYRNS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29713

Registered No. 73

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City or Laidlaw Park

If death occurs away from usual residence, give facts called for under special information. 31 miles North of Kimama Ida

(No. ..... St.)

2. FULL NAME Geo R Herman

Registration District No. .....

Primary Registration District No. 1018

(No. 1)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): unknown

6. DATE OF BIRTH. Nov 11 1878 (Month) (Day) (Year)

7. AGE: 41 Yrs. 4 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Sheepherder no

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ed Jackson

(Address) Kimama

15. Filed Feb 5 1920

J L Fuller Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

as far as could be learned

16. DATE OF DEATH death occured March 2 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

M D in attendance

Verdict on Jury accepted death is possible Suicide

under (Duration) Cremps Lunger ds.

Contributory (Secondary) could from other

(Duration ... yrs. ... mos. ... ds.

(Signed) Lincoln Phys. is M. D.

19... (Address) not Battlon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 4-3-1920

20. UNDERTAKER: O J Brennan — ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 16

County of Lincoln

Primary Registration District No. 1016

City of Shoshone (No. ..... St.)

File No. 23444

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Oliver Fuller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	American	Child Infant

6. DATE OF BIRTH. Mar 31 1920
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Shoshone Lincoln Co Idaho

10. NAME OF FATHER John L Fuller

11. BIRTHPLACE OF FATHER (State or Country) Idaho Lincoln Co.

12. MAIDEN NAME OF MOTHER Beulah Dunn

13. BIRTHPLACE OF MOTHER (State or Country) Lincoln Co Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John L Fuller
(Address) Shoshone Ida

15. Filed April 3 1920 J. L. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 3 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 31 1920 to Apr 3 1920, that I last saw him alive on Apr 3 1920, and that death occured on the date stated above, at 7:30 A M.

The CAUSE OF DEATH* was as follows:

secondary asphyxia
from atelectasis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G P Jones M. D.
19 (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 16

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 1016
File No. 29715
Registered No. 11

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francisco Legarsa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 4 1904
(Month) (Day) (Year)

7. AGE: 18 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Benito Legarsa

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Angela Guesuraga

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Federico Legarsa
(Address) Shoshone

15. Filed March 31 1920 J. Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 30 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1920, to March 30 1920, that I last saw h[illegible] alive on March 30 1920, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
.....
.....
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Exhaustion
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
3/31 1920 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone
DATE OF BURIAL: 4-1 1920

20. UNDERTAKER: O. J. Brennan
ADDRESS: Shoshone

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-19

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF VITAL STATISTICS
Bureau of Vital Statistics

File No. 29716

Registered No. 10

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City of Owsley

Registration District No. 16

Primary Registration District No. 2016

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Salazar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. dont-Known ..... (Month) ..... (Day) 1 (Year)

7. AGE about 57 years ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: R R Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Jesus Salazar

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Maria Sanchez

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernigen Guilley

(Address) Owsley Idaho

15. Filed March 30 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

No M D in attendance

coroners jury verdict -

accidental death

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

March 30 19 20 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence 3-29-20

19. PLACE OF BURIAL OR REMOVAL: Owsley

DATE OF BURIAL ..... 191...

20. UNDERTAKER: Shoshone

ADDRESS Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
File No. 2971
Registered No. 9

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary O'Shaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow
6. DATE OF BIRTH. Feb 22 1834 (Month) (Day) (Year)
7. AGE: 85 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Ireland
10. NAME OF FATHER Owen Mullin
11. BIRTHPLACE OF FATHER (State or Country) Ireland
12. MAIDEN NAME OF MOTHER Rose Mullin
13. BIRTHPLACE OF MOTHER (State or Country) Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Terry Murphy
(Address) Shoshone
15. Filed March 25 1912 J. Fraser Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 25 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 1st 1920, to March 25 1920, that I last saw h er alive on March 20 1920, and that death occured on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Paralysis
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Hard work
..... (Duration ..... yrs. ..... mos. ..... ds.
3/26 1920 (Signed) ..... M. D.
(Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: 3-26 1920
20. UNDERTAKER: O J Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 17

County of Lincoln

Primary Registration District No. 22

File No. 7 2970

City of Rockfield 1½ mi N.W. (No. ..... St.)

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Grace E. Bolton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept 21 1879 (Month) (Day) (Year)

7. AGE: 40 Yrs. 5 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housemift

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Monro. Co Tenn

10. NAME OF FATHER: Laurence L. Faukner

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Clara Johnston

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. E. Bolton.

(Address) Burma Idaho

15. Filed March 12 1920 P. E. Bartlett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 10, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ was called to on March 10 1920, to ..... 19.....
never
that I last saw h~~er~~ alive on ..... 19.....,
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

acute dilatation of heart

(Duration) ..... Yrs. Less than 1 mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) C. P. Jones M. D.

3/12 1920 (Address) Shoshone

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockfield Cemetery — DATE OF BURIAL: 3/12 1920

20. UNDERTAKER: Hugh Reuton — ADDRESS: Rockfield

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. S 29719

Registered No. 6

1. PLACE OF DEATH.
County of Lincoln
City of Richfield
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2220
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Helen Rose Baby Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH: June (Month) 28 (Day) 1919 (Year)

7. AGE: — yrs. 8 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Baby
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Richfield Co. Lincoln Co. Idaho

10. NAME OF FATHER: Herman Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna Nordlund

13. BIRTHPLACE OF MOTHER (State or Country): Finland Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herman Anderson
(Address) Richfield Idaho.

15.
Filed March 22 1920 P. E. Burtt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920, to Feb 20 1920 that I last saw her alive on Feb. 20 1920, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Flu,

(Duration) ..... yrs. ..... mos. 30 ds.

Contributory (Secondary) Malnutrition

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

3/24 1920 (Address) Lincoln Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Richfield Cemetery
DATE OF BURIAL: 3/22 1920

20. UNDERTAKER: Lyn Hinton
ADDRESS: Richfield Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29720

Registered No.

1. **PLACE OF DEATH**

County of Madison

City of Sugar (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME**

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: March (Month) 24 (Day) 1920 (Year)

7. **AGE**: ✓ Yrs. ✓ Mos. 2 ds.

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Sugar City Madison Co Idaho.

10. **NAME OF FATHER**: Charles Orson Hamilton

11. **BIRTHPLACE OF FATHER** (State or Country): Utah

12. **MAIDEN NAME OF MOTHER**: Pearl Anderson

13. **BIRTHPLACE OF MOTHER** (State or Country): Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant): Lorin F. Rich

(Address): Rexburg Idaho.

15. Filed 3-27 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: March (Month) 26 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from March 24 1920, to March 26 1920, that I last saw him alive on March 26 1920, and that death occurred on the date stated above, at 7.25 P.M.

The **CAUSE OF DEATH*** was as follows:

Premature birth
at seventh month

(Duration) Yrs. mos. ds.

Contributory (Secondary): Premature birth

(Duration) ✓ yrs. ✓ mos. 2 ds.

(Signed) Lorin F. Rich M. D.

3/31 1920 (Address) Rexburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** | **DATE OF BURIAL** 19...

20. **UNDERTAKER** | **ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 29721
Registered No. 472

1. PLACE OF DEATH

County of Madison
City of Rexburg (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vesta B. Robinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: May (Month) Third (Day) 1891 (Year)

7. AGE: 29 Yrs. 10 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Wyoming

10. NAME OF FATHER: James W. Bainbridge

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER: Anna Lewis

13. BIRTHPLACE OF MOTHER (State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Bainbridge
(Address) Driggs, Ida.

15. Filed 3/14 1920 G. E. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-27 1920 to 3-14 1920 that I last saw her alive on 3-13-1920, and that death occurred on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 7 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Espe M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Daniel, Wyoming.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg, Ida.	3-15 1920
20. UNDERTAKER	**ADDRESS**
David R. Young	Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29722
Registered No. 41

1. PLACE OF DEATH

County of Madison

City of Rexburg

(No. ..... St.)

Registration District No. 100

Primary Registration District No. 2178

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Schmith Kreutzer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: October 20 1858 (Month) (Day) (Year)

7. AGE: 60 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Michael Schmith

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) August Kreutzer

(Address) Harmer, Idaho

15. Filed 3-1 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1920 to Mar 10 1920 that I last saw her alive on Mar 10 1920 and that death occurred on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows: Leukemia, Lymphoid

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Josephine Walker M. D.

19 ..... (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 3 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Unknown

Former or usual residence Roberts Ida.

19. PLACE OF BURIAL OR REMOVAL: Roberts, Idaho

DATE OF BURIAL: 3-12-1920

20. UNDERTAKER: D. R. Young

ADDRESS: Rexburg, Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 29723
Registered No. 28

1. PLACE OF DEATH.
County of Minidoka
City of Heyburn P.O.
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Williamson Magnus Jolley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 8 (Day) 1888 (Year)

7. AGE: 31 Yrs. 3 Mos. 27 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mt Carmel Utah

10. NAME OF FATHER: Wm. M Jolley

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Lydia A Brimhall

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harvey Moncur
(Address) Heyburn Route 1

15. Filed March 27 1920 — E. B. Calvert, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 28 1920 to Feb 5 1920, that I last saw h[e] alive on Nov 4 1920, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Spanish influenza
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary): Broncho-pneumonia
(Duration yrs. mos. 10 ds.
(Signed) H. E. Adams M. D.
Mar 29 20 (Address) Burley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 15 yrs. mos. days. In the State 15 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cem Burley — DATE OF BURIAL: Feb 191

20. UNDERTAKER: L B Gallogly — ADDRESS: Burley Ida

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 29724
Registered No. 25

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura A Bayliss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 26 (Day) 1879 (Year)

7. AGE: 40 Yrs. 5 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. H. Perry

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Annie Smith

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Albert E Bayliss
(Address):

15. Filed March 22 1920 — E A Elmore, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11 1920, to March 18 1920, that I last saw her alive on March 18 1920, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary): Influenza

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) E A Elmore M. D.

9-22 1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cecropia Cemetery	Mar 8 1920
20. UNDERTAKER	**ADDRESS**
W. G. Goodman	Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 29726
Registered No. 19

1. PLACE OF DEATH.
County of Minidoka
City of Heyburn
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alonzo Ray McCord.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. Feb (Month) 26 (Day) 1903. (Year)

7. AGE: 16 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER William Thomas McCord.

11. BIRTHPLACE OF FATHER (State or Country) Missouri.

12. MAIDEN NAME OF MOTHER Era Morris.

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William Thomas McCord.
(Address) Heyburn Ida

15.
Filed April 9 1920 E. E. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 30 1920, to Feby 6 1920, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 7:10 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) J. F. Kaulter M. D.

19.... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cem — DATE OF BURIAL: Feb 8th 1920

20. UNDERTAKER: L. S. Galloghy — ADDRESS: Burley Ida

Dr Kaulter

BYRNE - YORK CO. PTGS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29729

Registered No. 22

Registration District No. 19

Primary Registration District No. 2015

1. PLACE OF DEATH

County of Minidoka

City of Rupert (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melone E Phubbs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1862 (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: Adline Bolt

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Phubbs

(Address) Rupert Idaho

15. Filed Mar. 22 1920 E V Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to Feb 13 1920, that I last saw her alive on Feb 5 1920, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Disease

(Duration) 7 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Bronchitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E V Elmore M. D.

3-22-1920 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Feb 16 1920

20. UNDERTAKER: W. A. Gardner — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2013
File No. 29750
Registered No. 23

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Winifred Stowell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1898 (Year)

7. AGE: 21 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Alexander Stowell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary A. Williams

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alexander Stowell
(Address) Rupert Idaho

15. Filed Mar 22 1920 E. O. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 12 1919, to march 3 1920, that I last saw her alive on march 2 1920, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) 5 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Mitral Regurgitation
(Duration) 1 yrs. ..... mos. ..... ds.
(Signed) E. O. Elmore M. D.
3-22 1920 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Mar 3 1920
20. UNDERTAKER: W. A. Anderson — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 25751
Registered No. 24

1. PLACE OF DEATH.
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elbourg Tidd.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Child (write the word.)

6. DATE OF BIRTH
Mar 4 (Month) 4 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 10 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Gilbert Tidd.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Annie Staley

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John B Tidd
(Address) Rupert Idaho.

15.
Filed March 22 1920 E. H. Elmore
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar 5. (Month) 2:00 A. M. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1920, to March 4 1920
that I last saw h.er alive on March 4 1920
and that death occurred on the date stated above, at 2 a. M.
The CAUSE OF DEATH* was as follows:
Atelectasis

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. H. Elmore M. D.
3-22 1920 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Mar 19 7
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 2013
File No. 23133
Registered No. 27

1. PLACE OF DEATH
County of Minidoka
City of Heyburn
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stilborn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write this word.): Child

6. DATE OF BIRTH: Feb 18 (Month) (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or 3 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clarence Cox

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Nina Hall

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Arthur Cox
(Address): Rupert Idaho

15. Filed March 22 1920 E. V. Elsmore Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1920, to — 19..... that I last saw h..... alive on — 19..... and that death occurred on the date stated above, at — M.
The CAUSE OF DEATH* was as follows:
Stillborn
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
3-22 1920 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Heyburn Cemetery — DATE OF BURIAL: Feb 19 1920

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 29734
Registered No. 29

1. PLACE OF DEATH.
County of Minidoka
City of Heyburn
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Royden Ernest Stimpson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Nov (Month) 28 (Day) 1917 (Year)
7. AGE: 2 Yrs. 3 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ogden Utah
10. NAME OF FATHER: William E. Stimpson
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Martha Heiner
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm E Stimpson
(Address) Heyburn Ida
15. Filed Apr. 9 1920 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 23 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1920, to Mar 20 1920, that I last saw him alive on Mar 20 1920, and that death occured on the date stated above, at 4:30 A. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Pneumonia + Septicemia
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F H Cutler M. D.
19..... (Address) Burley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Heyburn Cemetery — DATE OF BURIAL: Mar 25 1920
20. UNDERTAKER: L. O. Gallogly — ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

DA Cutler

SVMS - YORK CO., Inc. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 14

Primary Registration District No. 2015

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29735

Registered No. 30

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Paul

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Parlee Byrum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 24 (Day) 1873 (Year)

7. AGE: 47 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chauncey Edwin Byrum

(Address) Paul Ida

15.

Filed 4 — 9 1920

E H Elmore
Local Registrar

SVMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 22 1920, to Mch. 11 1920, that I last saw h[illegible] alive on Mch. 4 1920 and that death occured on the date stated above, at 4:20 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) 1 yrs. ..... mos. ..... ds.

(Signed) R. V. Darby M. D.

3/18 1920 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paul Cemetery | DATE OF BURIAL: Mar 13 1920

20. UNDERTAKER: L B Gallogly | ADDRESS: Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 69736
Registered No. 2

1. PLACE OF DEATH
County of Nezperce
City of Tullock
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel G. Sardam

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: 4 (Month) 26 (Day) 1876 (Year)

7. AGE: 43 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Port Sardam

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Nodie Goodman

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Yount
(Address) Tullock, Idaho.

15. Filed 3-2- 1920
E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 27 1920 to Mar. 1 1920
that I last saw h[illegible] alive on Mar. 1 1920
and that death occurred on the date stated above, at 11.45 A. M.
The CAUSE OF DEATH* was as follows:

Empyema

(Duration) 0 Yrs. 0 mos. 10 ds.
Contributory (Secondary) Tobacco pneumonia
(Duration) 0 yrs. 0 mos. 23 ds.

(Signed) W. Atwood Gore, M. D.
3/1 1920 (Address) Pierce, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash — DATE OF BURIAL ..... 19....

20. UNDERTAKER: [illegible] Goodland — ADDRESS Defford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Nez Perce
City of Southwick

Registration District No. 92
Primary Registration District No. 2170
(No. .... St.)

File No. 29737
Registered No. 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hattie May Douglas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. Feb (Month) – 20 (Day) 1882 (Year)

7. AGE 37 Yrs. 11 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER George Berreman

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Maggie Hoke

13. BIRTHPLACE OF MOTHER (State or Country) Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Stephen A Douglas
(Address) Southwick Ida.

15. Filed 3- 5- 1920 E. E. Watts Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) – 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Feb 12 1920, that I last saw her alive on Feb. 12 1920, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:
Influenza and complications following premature Child Birth 17 ds
(Duration) 0 Yrs. 0 mos. 25 ds.
Contributory (Secondary) Hypertrophy of the Heart
(Duration 0 yrs. 0 mos. 25 ds.
(Signed) Russell Truitt M. D.
1920 (Address) Southwick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Southwick Ida Cemetery — DATE OF BURIAL Feb 14 1920

20. UNDERTAKER S A Douglas (Acting) — ADDRESS Southwick Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29738
Registered No. 379

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston, Ida.
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lovina Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March (Month) 6th (Day) 920 (Year)

7. AGE: 23 Yrs. 4 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Charley Cox

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary Happ

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.R. Johnson
(Address) Orofino, Ida

15. Filed Apr 10 1920 Emma E. Brown Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 6 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1920, to March 6 1920
that I last saw h.. alive on March 6 1920,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Acute Mycarditis
& General Peritonitis

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Double Pneumonia & Influenza
(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) Edgar L. White M. D.
March 7 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino, Ida. DATE OF BURIAL: Mar. 8 19 20

20. UNDERTAKER: H.R. Merchant ADDRESS: Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 6-25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. ..... , ... St.)

File No. 29739

Registered No. 380

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo. W. Dodd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Sept. 27 (Month) (Day) 1848 (Year)

7. AGE: 71 Yrs. 5 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James Dodd

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sarah McMillan

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Dodd
(Address) Craig, Wash.

15. Filed Mar 10, 1920 — Susan E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 9 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5, 1920, to March 9, 1920, that I last saw him alive on March 9, 1920, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary): Arterio Sclerosis

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) E. L. White, M. D.

March 9, 1921 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clarkston, Wash	Mar. 11, 1920

20. UNDERTAKER	ADDRESS
H. R. Merchant	Clarkston

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29740
Registered No. 382

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 719 - 5th Ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bert Reed
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Not known (Month) (Day) (Year)

7. AGE: 50 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Vassar Coroner
(Address) Lewiston Ida.

15. Filed Apr 10 1920 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-14-1920, to 3-14-1920 that I last saw h— alive on Dead 3-14-1920 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Disorganization from unknown cause

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) John N Culley M.D.
3-16-1920 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 3/17/1920

20. UNDERTAKER: J Vassar — ADDRESS: Lewiston

19
29
16
4

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29741
Registered No. 383

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston
(No. 817 — 8th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo L Riggs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	married

6. DATE OF BIRTH March 27 1864
(Month) (Day) (Year)

7. AGE 55 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ken.

10. NAME OF FATHER Sylvester L Riggs

11. BIRTHPLACE OF FATHER (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER " " "

13. BIRTHPLACE OF MOTHER (State or Country) " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo L Riggs
(Address)

15. Filed Apr 10 1920 Dixon E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 16 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12th 1920, to Mar. 16th 1920, that I last saw him alive on Mar. 16th 1920, and that death occurred on the date stated above, at 1145 A.M.

The CAUSE OF DEATH* was as follows:
Cerebral Thrombosis or Embolism

(Duration) ..... Yrs. ..... mos. 64 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McMahan M. D.
3-16-1920 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston
DATE OF BURIAL 18 — 1920

20. UNDERTAKER Hasson
ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1909
File No. 29742
Registered No. 384

1. PLACE OF DEATH

County of Nez Perce
City of Orchards (No. Lewiston Orchards St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. W. Hutchinson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Single

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE 53 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Canada.

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. M Fischel

(Address) Lewiston Orchards

15. Filed Apr 10 1920 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20th 1920; to no date 19..... that I last saw him alive on Dec. 20th 1920; and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Probably Cerbral Hemorrhage.

..... (Duration) ..... Yrs. ..... mos. 6 hrs ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McMahan M. D.

3-20 1920 (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Calvington Mem	Mar 1920

20. UNDERTAKER	ADDRESS
J Wasson	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 20743
Registered No. 284

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 1st & 4th Normal St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hannah McKenzie
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Jan 10 (Month) (Day) 1837 (Year)

7. AGE: 83 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Wm Fraser

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Jessie Fraser

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E. A. White
(Address) Lewiston

15. Filed Ap 10 1920 Dawn E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 26 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1920, to March 26 1920 that I last saw h. on alive on March 26 1920 and that death occurred on the date stated above, at 430 P.M.
The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Aortic Regurgitation
(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. A. Broadbent M. D.
March 26 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 3/28 1920

20. UNDERTAKER: Hasson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 29744
Registered No. 386

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. W Bates Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Elsie Case
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Married

6. DATE OF BIRTH: Dec. (Month) 5th (Day) 1892 (Year)

7. AGE: 28 Yrs. Mos. 3 ds. 26
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk.
(b) General nature of industry, business or establishment in which employed (or employer): Dr. Parker

9. BIRTHPLACE (State or Country): Kendrick, Idaho.

10. NAME OF FATHER: Barton W. Strain

11. BIRTHPLACE OF FATHER (State or Country): Illinois,

12. MAIDEN NAME OF MOTHER: Missagnes Hall.

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Barton W. Strain
(Address) 527 - Delsol St.

15. Filed Apr 10 1920
Byron E Bussor
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1920, to March 29 1920
that I last saw her alive on March 29 1920
and that death occurred on the date stated above, at 10 30 P.M.
The CAUSE OF DEATH* was as follows:
acute general peritonitis

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary): Double pyosalpinx

(Duration) yrs. mos. ds.

(Signed) Edgar L. White M. D.
3-30 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: Mar 31 1920

20. UNDERTAKER: C J Vasso — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

File No. 29745

Registered No. 381

County of Nez Perce

City of Lewiston (No. White Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilford Eugene Sayer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	S

6. DATE OF BIRTH: 3 (Month) 6 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lewiston Ida

10. NAME OF FATHER W. E. Sayer

11. BIRTHPLACE OF FATHER (State or Country) Neb.

12. MAIDEN NAME OF MOTHER Flora Nelson.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy C Pauley.
(Address) White Hospital

15.
Filed Apr 16 1920 Norm E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1920, to March 12 1920 that I last saw h alive on March 12 1920 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Wall M. D.

19 ..... (Address) Lewiston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida.	3/13 1920

20. UNDERTAKER	ADDRESS
C Larson	Lewiston.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29746
Registered No. 377

1. PLACE OF DEATH.
County of Nezperce
City of Lewiston
Registration District No. 96
Primary Registration District No. 1009
(No. 1705, 6 — St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Violan Atkinson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 3 (Month) — 6 (Day) — 1918 (Year)

7. AGE: 2 yrs. 4 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Frank W. Atkinson

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Katherine Walker

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank W. Atkinson
(Address) 1705-9th St. Lewiston, Idaho

15.
Filed Mch 10 1920 Susan E Breen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch — 5 — 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920, to Mch 5 1920, that I last saw her alive on Mch 4 1920 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Lethargic Encephalitis
following Influenza

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paulo Johnson M. D.
Mch 10 1920 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 3/6 1920

20. UNDERTAKER: Lassar
ADDRESS: Lewiston Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. ..... St.)

File No. 29747
Registered No. 378

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Fulton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	

6. DATE OF BIRTH: January (Month) 26 (Day) 920 (Year)

7. AGE: Yrs. 1 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lewiston, Ida.

10. NAME OF FATHER F.J.Fulton

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Bertha Luedtke

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F.J.Fulton
(Address) Clarkston, Wash.

15. Filed Apr 10 1920 Susan E Brown
Local Registrar

STAR-TIMES CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to March 5 1920, that I last saw h.im alive on March 5 1920, and that death occurred on the date stated above, at 11.30 A.M. P.M.
The CAUSE OF DEATH* was as follows:

Mal nutrition & Flue.

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. White M. D.
March 6 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clarkston, Wash	Mar. 7 1920
20. UNDERTAKER	**ADDRESS**
H.R.Merchant	Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29748

Registered No. V.

1. PLACE OF DEATH.

County of Nez Perce

City of Lapwai

(No. 2174 St.)

Registration District No.

Primary Registration District No. 97

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Laymond Craig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) (Year): 1859

7. AGE: 61 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James H. Craig

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Elizabeth Loyd

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Mrs Martha Sherry Craig

(Address): Lapwai Idaho

15. Filed March 20 1920 Theo. Pfaff Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 8 1920, to March 13 1920, that I last saw him alive on March 12 1920, and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Labar pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary) Ptomaine poisoning

(Duration yrs. mos. 2 ds.

(Signed) Claude E Sims M. D.

3/23/1920 (Address) Lapwai Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? ✓

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lapwai Ida — DATE OF BURIAL: 3/14/1920

20. UNDERTAKER: L. B. Mann — ADDRESS: Lapwai Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & STRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 97

Primary Registration District No. 2774

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29749

Registered No. 3

1. PLACE OF DEATH.

County of Nez Perce

City of Lapwai

(No. Ft. Lapwai Sanatorium. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Moses.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	Indian	Single (Write the word.)

6. DATE OF BIRTH.

(Month) (Day) 1909 (Year)

7. AGE

11 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... School girl.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Nez Perce.

10. NAME OF FATHER James Moses Jr.

11. BIRTHPLACE OF FATHER

(State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Delia Seth.

13. BIRTHPLACE OF MOTHER

(State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Corbett Lawyer.

(Address) Lapwai Ida.

15.

Filed March 20 1920

Chas. P. Hatch
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1917, to Mch. 18 1920, that I last saw her alive on Mch. 17 1920, and that death occured on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.

(Duration) Yrs. mos. ds.

Contributory (Secondary) Pulmonary Tuberculosis.

(Duration 3 yrs. mos. ds.

(Signed) Claude E Sims M. D.

3/18 1920 (Address) Lapwai Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 3 yrs. ✓ mos. ✓ days In the State 11 yrs. ✓ mos. ✓ days

Where was disease contracted if not at place of death? at home.

Former or usual residence Lapwai. Ida.

19. PLACE OF BURIAL OR REMOVAL: Spalding. Idaho.

DATE OF BURIAL: 3/18 1920

20. UNDERTAKER: L. B. Nawn

ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 43
Primary Registration District No. 2120
File No. 5150
Registered No.

1. PLACE OF DEATH.
County of Owyhee
City of Silver (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Sawley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (?) (Month) (Day) 1842 (Year)

7. AGE: 78 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown.

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dave O'Neil
(Address) Silver City Idaho.

15.
Filed March 30 1920 W. H. Schuyler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 26th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 15 1920, to March 26, 1920, that I last saw h[illegible] alive on March 20, 1920 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Heart disease, mitral stenosis, & Chronic Nephritis, & Chronic cystitis.

(Duration) about 3 yrs. — mos. — ds.

Contributory (Secondary) Heart affection followed by chronic nephritis. (Duration) 2 yrs. — mos. — ds.

(Signed) W. H. Schuyler M. D.
March 30 1920 (Address) Silver City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: By I.O.O.F. Cemetary
DATE OF BURIAL: March 28th 1920

20. UNDERTAKER: John Grete
ADDRESS: Silver City Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 43
County of Owyhee. Primary Registration District No. 2120
City of Silver (No. ....., ... St.)
File No. 29751
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Steve Schuckle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Unknown 1
(Month) (Day) (Year)

7. AGE
52 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or dstablishment in which employed (or employer) worked for himself.

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. D. Brumbaugh
(Address) Silver City.

15.
Filed March 9, 1920 W. H. Schuyler, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I last saw h..... alive on ....., 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Found dead in his cabin, (no signs of foul play,) death due to natural causes, probably an attack of heart failure following influenza.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Supposed to have a weak heart, of long standing
(Duration) (2) yrs. ..... mos. ..... ds.

(Signed) W. H. Schuyler M. D.
Mar. 9, 1920 (Address) Silver City, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetary — DATE OF BURIAL: Mar 12 1920

20. UNDERTAKER: John Grute — ADDRESS: Silver City.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29752
Registered No. .....

1. PLACE OF DEATH.
County of Owyhee
City of Murphy (Near) (No. ....., 2120 St.)
Registration District No. .....
Primary Registration District No. 43
If death occurs away from usual residence, give facts called for under special information. 18 miles from Murphy
2. FULL NAME Joseph H. Klines

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant
6. DATE OF BIRTH. March (Month) 18 (Day) 919 (Year)
7. AGE: 0 Yrs. 10 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE. (State or Country) Idaho
10. NAME OF FATHER Joseph H. Klines
11. BIRTHPLACE OF FATHER (State or Country) Ill.
12. MAIDEN NAME OF MOTHER Agnes Hoyfud
13. BIRTHPLACE OF MOTHER (State or Country) Austria
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joseph H. Klines
(Address) .....
15.
Filed May 31, 1920 W. H. DeHuyler Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24958

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 31 (Day) 20 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ——— 191— to ——— 191—
that I last saw h— alive on ——— 191—
and that death occured on the date stated above, at ——— M.
The CAUSE OF DEATH* was as follows:,
Pneumonia following Influenza
(Duration) — Yrs. — mos. 12 ds.
Contributory (Secondary) Mal-nutrition
(Duration ... yrs. ... mos. ... ds.
(Signed) W. H. DeHuyler M. D.
19.... (Address) Silver City & Murphy Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa	Feby. 6 1920
20. UNDERTAKER Robinson	ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 39
Primary Registration District No. 2187

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29754
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burl
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hope Fritcher
(No. , St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: November (Month) 13 (Day) 1919 (Year)

7. AGE: — Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burl

10. NAME OF FATHER: Glenn F Fritcher

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Nora Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Thos. L. Fritcher
(Address): Burl, Idaho.

15. Filed Apr 1 1920 — J. F. Murphy, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1920 to Mar 29 1920, that I last saw h.. alive on 3/29 1920, and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Pertussis

(Duration) ..... Yrs. ..... mos. 25 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. J. McClusky M. D.
3/29 1920 (Address) Burl Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burl Cemetery — DATE OF BURIAL: Mar 30 1920
20. UNDERTAKER: Neville & Rugg. — ADDRESS: Burl

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 39

Primary Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29755

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of Buhl

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Isabelle Babcock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	(Write the word) Married

6. DATE OF BIRTH: December 29 1890
(Month) (Day) (Year)

7. AGE: 29 Yrs. 2 Mos. 15 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: P. D. Neer

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Delia Roper

13. BIRTHPLACE OF MOTHER (State or Country): Not Known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sidney J. Babcock
(Address) Buhl Idaho.

15. Filed Mar 18 1920. J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 14 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1920 to March 14 1920 that I last saw her alive on March 14 1920 and that death occurred on the date stated above, at 2.00 A.M.

The CAUSE OF DEATH* was as follows:

Influenza, Hypostatic pneumonia, Influenzal meningitis.

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) Interstitial Nephritis Uremia

(Duration) — yrs. — mos. 1 ds.

(Signed) F. A. Irmen. M. D.

Mch 14 1920 (Address) Buhl Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) Died at Buhl.

At place of death X yrs. X mos. 3 days. In the State X yrs. X mos. X days

Where was disease contracted if not at place of death? at Castleford.

Former or usual residence at Castleford.

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Cemetery — DATE OF BURIAL: Mar 19 1920

20. UNDERTAKER: Neville & Trigg. — ADDRESS: Buhl Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 39

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29756
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl.
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 2187
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Margaretta Rogers.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.)
Fem	White	Single

6. DATE OF BIRTH: January (Month) 27 (Day) 1920 (Year)

7. AGE: — Yrs. 1 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ✓
(b) General nature of industry, business or establishment in which employed (or employer) ✓

9. BIRTHPLACE (State or Country) Buhl

10. NAME OF FATHER V. B. Rogers.

11. BIRTHPLACE OF FATHER (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Edith Wiggins

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) V. B. Rogers
(Address) Buhl Idaho

15. Filed Mar. 3 1920 J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-9- 1920 to 3-9- 1920 that I last saw her alive on 3-9- 1920, and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH* was as follows:

Found dead in bed.
Cause of death not known.
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) George Jennings M. D.
3-10 1920 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery	May 10 1920
20. UNDERTAKER Fowler & Fuqua	ADDRESS Buhl Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 39

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 29757
(No. ..... St.)
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls,
City of Buhl, Ida
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Katherine Morrison
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: September (Month) 8 (Day) 1874 (Year)

7. AGE: 45 Yrs. 5 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: Jacob Erismann

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST ~~OF~~ MY KNOWLEDGE
(Informant) W. R. Morrison.
(Address) .....

15. Filed ~~Feb~~ Mar. 1 1926 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1- 1919, to 2-28- 1920, that I last saw h[er] alive on 2-28 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Spine.

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Geo. E. Jennings M. D.
2-28 1920 (Address) Buhl. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: March, 1920

20. UNDERTAKER: J. C. Schmidt — ADDRESS: Buhl, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF Vital Statistics
Bureau of

Registration District No. 38
Primary Registration District No. 2086
File No. 29758
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME La Vina McCleary

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct (Month) 26 (Day) 1845 (Year)

7. AGE: 75 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Zacaria Ingis

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Adelina Cloud

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Minnie Smith
(Address) Burley Ida.

15. Filed 3-11 1920
A. A. Newberry
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920, to Mar 10 1920, that I last saw her alive on Mar 7 1920, and that death occured on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
3-11 1920 (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pelair Kas — DATE OF BURIAL: 1920

20. UNDERTAKER: F. E. Stoke — ADDRESS: Filer

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29759
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

2. FULL NAME J. H. Ball

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Nov. (Month) 26 (Day) 1843 (Year)

7. AGE: 76 Yrs. 5 Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER Samuel Ball

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Malala Hall

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth Ball
(Address) Filer

15. Filed Apl. 1 20 19[illegible] A A Newberry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920 to March 31 1920
that I last saw h/m alive on March 31 1920
and that death occurred on the date stated above, at 11:50 P. M.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
.....19.... (Address) Filer Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lot 5 Cemetery Filer — DATE OF BURIAL Apr 4 1920

20. UNDERTAKER F E Drake — ADDRESS Filer

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29760
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls
(No. ....., ... St.)
Registration District No. 37
Primary Registration District No. 1085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alaice Inona Jarman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb 25 (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. ..... Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Twin Falls

10. NAME OF FATHER A H Jarman

11. BIRTHPLACE OF FATHER (State or Country) Glendale Idaho

12. MAIDEN NAME OF MOTHER Laura Hill

13. BIRTHPLACE OF MOTHER (State or Country) Wellsville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. H. Jarman
(Address) .....

15. Filed Mar 8 1920 John F. Caughlin Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
March 7 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 7 1920, to March 7 1920, that I last saw her alive on March 7 1920, and that death occured on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia.

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Hal Bieler M. D.
3.7 1920 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Mar 8 1920

20. UNDERTAKER: L. E. Ewart — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29761
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1083
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Willis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Single

6. DATE OF BIRTH
Mar. (Month) 7 (Day) 1920 (Year)

7. AGE
0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas. Willis

11. BIRTHPLACE OF FATHER (State or Country) Arizona

12. MAIDEN NAME OF MOTHER Sadie Bush

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Willis
(Address) Twin Falls

15. Filed Mar 8 1920 John F. Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51067

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7 1920 to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Still born.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Breech Presentation
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver, M. D.
3/9 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	3/8 1920
20. UNDERTAKER	ADDRESS
J. F. Corcoran	Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29762

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of " "

Registration District No. 37

Primary Registration District No. 1083

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write word.)

6. DATE OF BIRTH. May 9 1919
(Month) (Day) (Year)

7. AGE: ..... Yrs. 9 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Bert Wright

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Gladys Bonnett

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Bert Wright
(Address) Twin Falls Ida.

15. Filed Mar. 3 1920 John F. Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar 1 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 1920, to Feb 29 1920, that I last saw her alive on Feb 29 1920, and that death occured on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
.....
.....
.....(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M.D.
3/1 1920 (Address) [redacted]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Mar 2 1920

20. UNDERTAKER: [redacted] — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29763

Registered No. .....

Registration District No. 37

Primary Registration District No. 1085

1. PLACE OF DEATH.

County of Twin Falls

City of .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John W Gibbons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Sept (Day) 26 (Year) 1842

7. AGE: 87 Yrs. 5 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Mo

10. NAME OF FATHER James Gibbons

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Mary M McClain

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. M. Givans

(Address) Jerome

15. Filed Mar 3 1929 John H Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Mar (Day) 1 1929

17. I HEREBY CERTIFY, That I ~~attended~~ deceased from ~~191~~ ....., to ~~191~~ ....., ~~that I last saw him alive on~~ Oct. 1928 and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cancer of face

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver M. D.

3/1 1929 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cedar Grove Mo — DATE OF BURIAL 1929

20. UNDERTAKER: L E Stewart — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29764

Registered No. .....

Registration District No. 37

Primary Registration District No. 1285

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie A Phipps

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 20 (Day) 1 (Year)

7. AGE: 39 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Washington Savage

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: Sarah E Roberts

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. W. Savage

(Address) Burley Idaho

15. Filed March 5 1920 John F Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1920, to March 3 1920, that I last saw h alive on March 3 1920, and that death occured on the date stated above, at 2 45' P.M.

The CAUSE OF DEATH* was as follows:

Cancer of breast.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Alva Swendsen M. D.

March 5 1920 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: March 5 1920

20. UNDERTAKER: J E Dewitt — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29765

Registration District No. 87
Primary Registration District No. 1085
(No. ..... St.)
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Franklin Stevens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
March (Month) 6 (Day) 1920 (Year)

7. AGE
..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER
Charles L. Stevens

11. BIRTHPLACE OF FATHER
(State or Country) Mo

12. MAIDEN NAME OF MOTHER
Rosa L Coffey

13. BIRTHPLACE OF MOTHER
(State or Country) Wyo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. F. Stevens
(Address) Twin Falls, Ida.

15.
Filed Mar 10 1920 John F. Caudillis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 4 1920, to March 6 1920
that I last saw him alive on March 6 1920
and that death occured on the date stated above, at 12 P.M.
The CAUSE OF DEATH* was as follows:
Congenital heart deformity

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. W. Clouchek M. D.
Mar 10 1920 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Mar 10 1920

20. UNDERTAKER: L E Merritt — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1053
(No. ..... St.)

File No. 29766
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of ( )
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Mathison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb 28 (Month) (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ray Mathison

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Edna Paulson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ray H Mathison
(Address) Twin Falls, Ida

15. Filed Mar 11 1920 John F. Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar 10 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1920, to March 11 1920, that I last saw h[illegible] alive on March 11 1920, and that death occured on the date stated above, at 11 30 A.M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H M Leta M. D.
3/12 1920 (Address) Twin Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State Res yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: American Falls Idaho | DATE OF BURIAL ..... 191...

20. UNDERTAKER: L E Dewett | ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNS - YORK CO., PTRS. & BNRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1082
File No. 29767
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha E. Prentiss

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug. (Month) 14 (Day) 1879 (Year)

7. AGE: 40 Yrs. 6 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kent

10. NAME OF FATHER: Samuel W. Hills

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Ida M. Robson

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. M. Prentiss
(Address) Jerome Ida.

15. Filed Mar 15 1920 John F. Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1920 to March 12 1920.
that I last saw h.. alive on March 12 1920
and that death occurred on the date stated above, at 10: a.m.
The CAUSE OF DEATH* was as follows:

Haemorrhage, cerebral

(Duration) ..... Yrs. ..... mos. 21 days

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William F. Passer M. D.
3/13 1920 (Address) Rupert.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 1/2 mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome
DATE OF BURIAL: 3/14 1920
20. UNDERTAKER: J. J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2976

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. [redacted]

(No. ..... St.)

2. FULL NAME Lura Blackburn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 26 (Day) 1917 (Year)

7. AGE: 2 Yrs. 2 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Fred Blackburn

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Tamsin Roberts

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lulu Blackburn

(Address) Twin Falls Ida

15. Filed Mar 22 1920 Fox Laughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February 20 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 14 1920 to Feb. 20 1920 that I last saw her alive on Feb. 19 1920 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

..... (Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E. D. Weaver M. D.

19..... (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 2/22/1920

20. UNDERTAKER: J. J. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of " " — Primary Registration District No. 1085

(No. ..... St.)

File No. 2977

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank L. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word): Widowed

6. DATE OF BIRTH: Don't know (Month) (Day) ..... (Year)

7. AGE: 44 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) furnished by Dave Daniels

(Address) Pocatello Idaho

15. Filed Mar 22 1920 John Naughton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 16 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 14th 1920 to March 16 1920 that I last saw h— alive on March 16 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Acidosis - Following Severe Gastric Hemorrhage.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Ulcer Stomach, Chr

(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) S. A. Iverson M. D.

3/18 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 3/19 1920

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 29771
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Eggersglues

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Oct. (Month) 4 (Day) 1869 (Year)

7. AGE: 50 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher & Bee
(b) General nature of industry, business or establishment in which employed (or employer): Industry (Retired)

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Greene
(Address) Twin Falls R.F.D #3

15. Filed Mar 24 19 20 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: About March (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Burial relieved from Attempt Suicide
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D J Grossman Coroner
3/22/1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days In the State Bound 3/22-1920 yrs. ... mos. ... days
Where was disease contracted if not at place of death? in Rock Creek Canyon
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 3/25 1920
20. UNDERTAKER: D J Grossman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29773

Registered No. .....

Registration District No. 37

Primary Registration District No. 1085

1. PLACE OF DEATH.

County of Twin Falls

City of .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mattie L McKuster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct 30 (Month) (Day) 1867 (Year)

7. AGE: 52 Yrs. 4 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Joseph Rutherford

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Mary Hardin

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.

(Informant) Mat. McKuster

(Address) Twin Falls

15. Filed March 25 1920 John F Caughley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 23 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1919, to March 23 1920, that I last saw her alive on March 15 1920, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

General

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F Caughley M. D.

3/24 1920 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Mar 27 1920

20. UNDERTAKER: E E Scott — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2977

1. PLACE OF DEATH
County of Twin Falls Registration District No. 27
Primary Registration District No. 1085
City of [illegible] (No. ..... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel A. Wick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married
6. DATE OF BIRTH: July 20 1890 (Month) (Day) (Year)
7. AGE: 29 Yrs. 8 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Illinois
10. NAME OF FATHER: Lafyett Wick
11. BIRTHPLACE OF FATHER (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Nancy Compton
13. BIRTHPLACE OF MOTHER (State or Country): Ill.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lafayette Wick
(Address) Twin Falls
15. Filed March 25 1920 John H. Naughton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 22 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from March 8 1920 to March 22 1920
that I last saw h[illegible] alive on March 22 1920
and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows:
R. Pneumonia (Strepto Coccus)
following appendectomy
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 1 5 ds.
(Signed) [illegible] M. D.
3/24 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 3/24 1920
20. UNDERTAKER: [illegible] Grossman — ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51082

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29775
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085

2. FULL NAME Georgia Lee Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Mar 5 (Month) 1920 (Day) (Year)

7. AGE
..... Yrs. ..... Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER: Will Clark

11. BIRTHPLACE OF FATHER
(State or Country) Ala

12. MAIDEN NAME OF MOTHER: Flasia Lee

13. BIRTHPLACE OF MOTHER
(State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. B. Clark
(Address) Rt 2 Jeffersonville Ga.

15.
Filed Mar 31 1920 John F. Caugh Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 28 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1920, to Mar 28 1920, that I last saw h[er] alive on Mar. 27, 1920 and that death occured on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 23 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Timmis M. D.
1920 (Address) 340 3rd W. North,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho
DATE OF BURIAL: 3-27 1920

20. UNDERTAKER: L. E. Veatch
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 29776
Registered No. .....

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harrold Asbury

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
June (Month) 4 (Day) 1909 (Year)

7. AGE
..... Yrs. [illegible] Mos. [illegible] ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER: Williswalter Asbury

11. BIRTHPLACE OF FATHER
(State or Country) Va

12. MAIDEN NAME OF MOTHER: Mary Acuff

13. BIRTHPLACE OF MOTHER
(State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wallis Asbury
(Address) Hansen Idaho

15.
Filed Mar 26 1920 John T. Caughlan Jr.
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar 25 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1920, to March 25 1920, that I last saw h[illegible] alive on March 25 1920, and that death occ[illegible] on the date stated above, at 2? P.M.

The CAUSE OF DEATH* was as follows:
Infection of throat (streptococcus with general [illegible] edema

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Coughlin M. D.
March 26 1920 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho
DATE OF BURIAL: Mar 27 1920

20. UNDERTAKER: L. E. Elwood
ADDRESS: Twin Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of .....
(No. ..... St.)

Registration District No. 37
Primary Registration District No. 1085

File No. 29777
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosetta Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. July (Month) 28 (Day) 1863 (Year)

7. AGE: 56 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Newyork

10. NAME OF FATHER: Nat Knower

11. BIRTHPLACE OF FATHER (State or Country): Newyork

12. MAIDEN NAME OF MOTHER: Percila Rinks

13. BIRTHPLACE OF MOTHER (State or Country): Newyork

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ethel Mason
(Address) Murtaugh, Ida

15. Filed Mar 16 1920 John F. Caudill Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-15 1920, to Mar 13 1920, that I last saw her alive on Mar 13 1920, and that death occured on the date stated above, at 1— P.M.

The CAUSE OF DEATH* was as follows:
Progressive Bulbar Paralysis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Davis M. D.
3/14 1920 (Address) Kimberly, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twinfalls Idaho — DATE OF BURIAL: Mar 14 1920

20. UNDERTAKER: L E Truett — ADDRESS: Twinfalls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

Dr Deane. Dr. Davis.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 37

Primary Registration District No. 2085

File No. 2977

County of Twin Falls

City of Kimberly (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie Lloyd Givens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: March 10 (Month) (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Kimberly, Idaho. Twin Falls County.

10. NAME OF FATHER: H. C. Givens.

11. BIRTHPLACE OF FATHER (State or Country): Altamont Tenn.

12. MAIDEN NAME OF MOTHER: Rachel Brown.

13. BIRTHPLACE OF MOTHER (State or Country): Beersheba Springs Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. C. Givens

(Address) Kimberly Ida.

15. Filed Mar 26 1920 John Lauenstein Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 26 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26th 1920 to March 26th 1920 that I last saw h.. in ~~Dead alive~~ on March 26 1920 and that death occurred on the date stated above, at 7.90 AM.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage.

..... (Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hubert C Deane M. D.

3/26 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

In place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: 3-27 1920

20. UNDERTAKER: F E Nevitt | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 29779
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Rose Worth
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ira T. Brackett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Feb. 6 (Month / Day) 1847 (Year)

7. AGE: 74 Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Alonza Brackett

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Dont. know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. E. Brackett
(Address) Rogerson Idaho

15. Filed Mar. 31 1920 John Kaupke Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1920 to March 29 1920 that I last saw h.. alive on March 29 1920, and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Spotted Fever
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm Keefe M. D.
3/31 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 3/31 1920

20. UNDERTAKER: J. J. Torrance — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Rock Creek (No. ..... St.)

Registration District No. 96

Primary Registration District No. .....

File No. 29780

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman Stucker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Mar 12 1841 (Month) (Day) (Year)

7. AGE: 79 Yrs. — Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Dont know

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dont know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bernard Stucker

(Address) Rock Creek, Ida

15. Filed Mar 14 1920 J. P. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7 1920 to Mar 13 1920 that I last saw him alive on Mar 13 1920 and that death occurred on the date stated above, at 6:25 P.M.

The CAUSE OF DEATH* was as follows:

Hematuria from growth on left ureter

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. P. Davis M. D.

3/15 1920 (Address) Kimberly Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rock Creek

DATE OF BURIAL: 3/16 1920

20. UNDERTAKER: J. J. Grossman

ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
File No. 2976
Registered No. 8

1. PLACE OF DEATH
County of Twin Falls
City of Rock Creek (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary C. Donroe
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word)

6. DATE OF BIRTH: June (Month) 18 (Day) 1880 (Year)

7. AGE: 39 Yrs. 8 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John T. Hansen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John T. Hansen
(Address) 223 4 Ave E. Twin Falls Idaho

15. Filed 3 — 6 1920 J N Davis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1919, to Mar 5 1920 that I last saw her alive on Mar 4 1920 and that death occurred on the date stated above, at 10 A M.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J N Davis M. D.
3/6 1920 (Address) Kimberly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rock Creek — DATE OF BURIAL: 3/7 1920

20. UNDERTAKER: J. F. Grosvenor — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 14 2982

Registered No.

1. **PLACE OF DEATH**

County of Lemhi

City of Dingo

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77

Primary Registration District No. 2176

(No. ..... St.)

2. **FULL NAME** Earl Wayne Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. **DATE OF BIRTH** February 16 1920
(Month) (Day) (Year)

7. **AGE** ..... Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer): Infant

9. **BIRTHPLACE** (State or Country) Wyoming.

10. **NAME OF FATHER** Eli Hill

11. **BIRTHPLACE OF FATHER** (State or Country) Utah

12. **MAIDEN NAME OF MOTHER** Mary Brown

13. **BIRTHPLACE OF MOTHER** (State or Country) Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mary Hill.
(Address) Dingo R.D. 2 Idaho.

15. Filed April 3rd 1920 Martha Marker
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** March 24 1920
(Month) (Day) (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from March 21 1920, to March 24 1920 that I last saw him alive on March 24 1920 and that death occurred on the date stated above, at 10' M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia
Complicating Influenza.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Martin M. D.

..... 19..... (Address) Dingo, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello	..... 19.....
20. UNDERTAKER Shipp & Nelson	ADDRESS Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 2978.
Registered No.

1. PLACE OF DEATH
County of Teton
City of Driggs
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ann Green
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: Nov (Month) 20 (Day) 1851 (Year)

7. AGE: 68 Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer): Housekeeper

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: John Hawker

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah N. Hawker

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. F. Green
(Address) Driggs Idaho.

15. Filed April 3rd 1920 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1920, to Mar 11 1920, that I last saw h.er alive on Mar 11 1920, and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
Complicating Influenza
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. H. Martin M. D.
19..... (Address) Driggs Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Utah Wyoming.

19. PLACE OF BURIAL OR REMOVAL: Teton Cemetery — DATE OF BURIAL: 3/14 1920

20. UNDERTAKER: C. F. Green ADDRESS Driggs, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Jefferson

City of Victor

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 77

Primary Registration District No. 2176

(No. ....., ... St.)

File No. 29784

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Blanchard.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male.	White	Single (Write the word.)

6. **DATE OF BIRTH** Jan 7th 1920
(Month) (Day) (Year)

7. **AGE** Yrs. 3 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business or establishment in which employed (or employer) Infant.

9. **BIRTHPLACE** (State or Country) Idaho.

10. **NAME OF FATHER** J Blanchard

11. **BIRTHPLACE OF FATHER** (State or Country) Idaho

12. **MAIDEN NAME OF MOTHER** Ballard

13. **BIRTHPLACE OF MOTHER** (State or Country) Idaho

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs J. R. Blanchard

(Address) Victor Idaho

15. Filed April 7th 1920 Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** April 6th 1920
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** April 5th 1920 to April 6th 1920

that I last saw him alive on Dead when seen by me and that death occurred on the date stated above, at 9 P.M.

The **CAUSE OF DEATH*** was as follows:

Marasmus. Baby was dead when first seen by me

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas H Martin M. D.

19..... (Address) Victor Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Victor Cemetary

DATE OF BURIAL 4/7 1920

20. **UNDERTAKER** .....

ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
(No. ..... , ... St.)

File No. 20785
Registered No. .....

1. **PLACE OF DEATH**

County of Lincoln
City of Alta, Wyoming
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Earnest Green.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** married
(Write the word.)

6. **DATE OF BIRTH** May 8th 1879
(Month) (Day) (Year)

7. **AGE** 40 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Farmer —
(b) General nature of industry, business or establishment in which employed (or employer) Farmer —

9. **BIRTHPLACE**
(State or Country) Utah.

10. **NAME OF FATHER** Curtis G Green

11. **BIRTHPLACE OF FATHER**
(State or Country) N Y.

12. **MAIDEN NAME OF MOTHER** Sara A Hamber

13. **BIRTHPLACE OF MOTHER**
(State or Country) Tongland.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Geo. B. Green
(Address) Driggs R F D #1

15.
Filed April 3rd 1920 Martha Marker
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** February 11 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, ~~That I attended deceased from~~
..... 19..... to ..... 19.....
~~that I last saw him~~ alive on ..... about 19.....
~~and~~ that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
caught in snow slide.
Bruised surface Right leg
mangled.
~~(Duration)~~ ..... Yrs. ..... mos. ..... ds.

~~Contributory~~ (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. B. Green M. D.
19..... (Address) Driggs R F D #1

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL ~~OR REMOVAL~~** Alta Wyoming

DATE OF BURIAL Feb 15 1920

20. **UNDERTAKER** C. Denny

ADDRESS Victor Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29786

Registered No. .....

Registration District No. 77

Primary Registration District No. 2176

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Teton

City of Victor

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dale Lymon Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October (Month) 19th (Day) 1918 (Year)

7. AGE: 1 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Elmer B Jones

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Amy Irene Barnhart

13. BIRTHPLACE OF MOTHER (State or Country) Louisiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alice L Barnhart

(Address) Felt Idaho.

15. Filed April 3rd 1920 Martha Marlett Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan. (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 21 1920, to Jan 22 1920, that I last saw h[illegible] alive on Jan 22 1920, and that death occured on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... Yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19..... (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Victor Idaho

DATE OF BURIAL Jan 24 1920

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 127

Primary Registration District No. 2400

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29787

Registered No. 5

1. PLACE OF DEATH.

County of Shoshone

City of Adair

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Velena Schimmelpfening

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 1 (Day) 1919 (Year)

7. AGE: — Yrs. 3 Mos. 7 ds.

IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer): None

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Schimmelpfening

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Margaret Rigue

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Schimmelpfening

(Address) Adair, Idaho

15. Filed Mar 10 1920 C. Busey, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 8 1920, to Mar 8 1920, that I last saw h er alive on Mar 8 1920, and that death occured on the date stated above, at 2 40 P M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) — Yrs. — mos. 5 ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) C. Busey M. D.

Mar 8 1920 (Address) Avery, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. 3 mos. 7 days In the State — yrs. 3 mos. 7 days

Where was disease contracted if not at place of death? —

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: St. Maries, Idaho — DATE OF BURIAL: Mar 10 1920

20. UNDERTAKER: Hunt and Co. — ADDRESS: St. Maries Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. ; St.)

Registration District No. 123
Primary Registration District No. 7701
File No. 29788
Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Carl Theodore Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH: Aug (Month) 31 (Day) 1904 (Year)

7. AGE: 15 yrs. 6 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kellogg, Idaho

10. NAME OF FATHER: James A Patterson

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Guthrie

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Patterson
(Address) Kellogg, Idaho.

15. Filed 4/3 1920 Geo. D Leaken Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31 1920, to April 1 1920
that I last saw h(im) alive on April 1 1920
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Hemmorhage, from mucous membranes cause unknown)
(Duration) yrs. 3 mos. ds.
Contributory (Secondary) Tobacular Heart disease
(Duration) 3 yrs. mos. ds.

(Signed) Geo. D. Kennett M. D.
April 1920 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho. DATE OF BURIAL: April 4th 1920

20. UNDERTAKER: M. C. Thornhill ADDRESS: Kellogg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

29789 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 123
County of Shoshone
Primary Registration District No. 7101
City of Wardner (No. ....., ... St.)
File No. 18
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W. Coleman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Black Dark
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 23 (Day) 1852 (Year)

7. AGE: 67 yrs. 4 mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: George W. Coleman

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: No information

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Coleman
(Address) Wardner

15. Filed 2/13 1920 Geo. S Leslie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feb. (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 5 1920, to Feb 18 1920, that I last saw h/im alive on Feb 18 1920 and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation
(Heart disease)

(Duration) 20 yrs. 29 mos. ..... ds.
Contributory (Secondary) Crushing injury to Left shoulder & Chest
(Duration) ..... yrs. 9 mos. 15 ds.

(Signed) Geo W Kennett M. D.
March 10 1920 (Address) Kellogg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho — DATE OF BURIAL: Mar 9 1920

20. UNDERTAKER: McKay Bros — ADDRESS: Kellogg Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

29790

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12½

Primary Registration District No. 1200

File No.

Registered No. 30

1. PLACE OF DEATH.

County of Shoshone

City of Gem Idaho (No. Gem Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph B Beckett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May (Month) 10 (Day) 1852 (Year)

7. AGE: 68 Yrs. 0 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Yes

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary A Riley

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G J Beckett

(Address) Wallace Ida

15. Filed 3/10 1920

H. C. Mowery
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1918 to 3/12 1920, that I last saw h-m alive on 3/11 1920 and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of bowels

(Duration) 2½ yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D Mowery M. D.

3/12 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah. DATE OF BURIAL: Mch 13 1920

20. UNDERTAKER: B. C. Merrell ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—PRESS FIRMLY—RECORD

SYMS - YORK CO., PTRS. & BDRS. 24653

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

29791

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2200
File No.
Registered No. 31

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.
(No. Hercules Mill St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Robert McGrath

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 26 yrs. — mos. — ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: millman
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Daniel McGrath

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Carolina Deary

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George D. McGrath
(Address) Burke Idaho.

15. Filed 3/20 1920 H.C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 18th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accident caught in belt and drawn into pulley

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo N Walker Justice of the Peace
Mar 19 1920 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wash	Mar 20th 1920
20. UNDERTAKER	ADDRESS
Hans Thompson	Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Registration District No. ....
Primary Registration District No. V
State File No. ....
Local Registrar's No. ....

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

(No. .... St.)

2. FULL NAME Robert McGrath

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	W	Single

6. DATE OF BIRTH: January (Month) Tenth (Day) 1893 (Year)

7. AGE: 26 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Millman
(b) General nature of industry, business or establishment in which employed (or employer): ....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF Father: Daniel McGrath

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Caroline Deery

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ....
(Address) ....

15.
Filed .... 19....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from .... 19.... to .... 19....,
that I last saw h[illegible] alive on .... 19....,
and that death occurred on the date stated above, at .... M.
The CAUSE OF DEATH* was as follows: Chronic Bronchitis Contributory Pneumonia Acute Contributory Heart Failure

(Duration) .... yrs. .... mos. .... ds.

Contributory (Secondary) ....
(Duration) .... yrs. .... mos. .... ds.

(Signed) .... M. D.
19.... (Address) ....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... ds.
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shoshone Cemetery	Mar 20 1920

20. UNDERTAKER: Ward & Co. ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29792
Registered No. 32

PLACE OF DEATH

County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 172
Primary Registration District No. 7200
(No. County Infirmary St.)

2. FULL NAME John Cuthbert Toney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 19 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) County Infirmary by Dan
(Address) Wallace Ida

15. Filed 3/25 1920 H. C. Mauer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1919, to 3/25 1920, that I last saw him alive on 3/24 1920 and that death occured on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Chr. Nephritis 7 Yrs. mos. 7 ds.
Contributory (Secondary) Chronic Cystitis
(Duration 4 yrs. mos. ds.

(Signed) James R. Bean M. D.
3/25 1920 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: 3/ 1920

20. UNDERTAKER: D. E. Worstell. — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, FILL MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact state of OCCUPATION is very important. See instructions on back of certificate.

STARR - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

Dr. Stockslager

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12

Primary Registration District No. 1200

File No. 29794

Registered No. 34

1. PLACE OF DEATH.

County of Shoshone

City of Burke (No. Burke St.) Idaho

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edmond Francis Forkelson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 16 (Day) 1 (Year)

7. AGE: 33 Yrs. 6 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Quarty mine

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: F. L. Forkelson

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Isabelle McCaig

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Fred L. Forkelson
(Address) Burke Idaho.

15. Filed 4/2 1920 H. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 31 1920 to April 1 1920, that I last saw him alive on Mch 31 1920, and that death occured on the date stated above, at 3:30 a M.

The CAUSE OF DEATH* was as follows:
Accidental Shooting

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Acute Infection Carotid Gland

(Duration) ..... yrs. ..... mos. 9 ds.

(Signed) L. B. Stockslager M. D.

4/3 1920 (Address) Wallace, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 1920.

20. UNDERTAKER: Bruce L. Worstell | ADDRESS: Wallace

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29125
Registered No. 96

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of American Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 25
Primary Registration District No. 2072
(No. Residence St.)

2. FULL NAME Geo P. Crookshite

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 20 (Day) 1851 (Year)

7. AGE: 68 Yrs. 8 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kennebec Co Wis.

10. NAME OF FATHER: Augustus T Crookshite

11. BIRTHPLACE OF FATHER (State or Country) N Y

12. MAIDEN NAME OF MOTHER: Hanna Parker

13. BIRTHPLACE OF MOTHER (State or Country) N Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul P. Crookshite
(Address) Am. Falls, Idaho

15. Filed Nov 17 1920 R. T. Nath Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920 to Mch 17 1920
that I last saw him alive on Mch 16 1920
and that death occurred on the date stated above, at 5.30 a M.

The CAUSE OF DEATH* was as follows:
General arterial
Sclerosis
Duration
(Duration) Yrs. mos. ds.
Contributory (Secondary) Cystitis
(Duration) Yrs. 1 0 mos. ds.

(Signed) Richard F Mock M. D.
Mch 19 20 (Address) American Falls,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 3 yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Wisconsin

19. PLACE OF BURIAL OR REMOVAL: Albansville Wis. DATE OF BURIAL: Nov 24 1920

20. UNDERTAKER: W W Davis ADDRESS: Am Falls Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2
Registered No. 97

Registration District No. 25
Primary Registration District No. 2072

1. PLACE OF DEATH
County of Power
City of American Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Enoch Elsbury
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or the word)

6. DATE OF BIRTH: January (Month) 23 (Day) 1856 (Year)

7. AGE: 64 Yrs. 2 Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): clothing merchant

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Thom B. Elsbury

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Ellen Blair

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nettie Elsbury
(Address) American Falls Ida

15. Filed 3/30/1920 R. F. Noth Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1918 to Mch 29 1920 that I last saw h. ~~m~~ alive on Mch 29 1920 and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Paralysis due to cerebral hemorrhage
on June 1, 1918
(Duration) 1 Yrs. 8 mos. 29 ds.
Contributory (Secondary) Apoplexy
(Duration) Yrs. mos. ds.
(Signed) Richard F. Noth M. D.
3/30 1920 (Address) American Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Georgetown, Ohio — DATE OF BURIAL: 3/30 1920

20. UNDERTAKER: Arthur W. Davis — ADDRESS: Am. Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

25197

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Payette

City of Payette

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

(No. [redacted] St.)

File No.

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Waldo M Paine

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

Nov. (Month) 16 (Day) 1833 (Year)

7. AGE

86 Yrs. 8 Mos. 14 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) Don't know

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ward Paine

(Address) Boise, Idaho

15. Filed Mar 9 1920. J.C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Mar (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5, 1920, to Mar 9 1920, that I last saw h[illegible] alive on Mar 9 1920 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Woodward M. D.

3/9 1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. ..... mos. ..... days. In the State..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise Idaho	Mar 9 1920
20. UNDERTAKER Glenn C Landon	ADDRESS Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

29795

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
(No. ..... St.)
File No. .....
Registered No. 17

1. PLACE OF DEATH
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George M Winkler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Sept (Month) 25 (Day) 1856 (Year)

7. AGE
63 Yrs. 7 Mos. ds. 7
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer) Merchant

9. BIRTHPLACE (State or Country) West Virginia

10. NAME OF FATHER George A Watkins

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Arthed E Shipton

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Winkler
(Address) Emmett Idaho

15.
Filed Mar 9 1920 J C Woodward Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1920 to Mar 9 1920
that I last saw h[illegible] alive on Mar 9 1920
and that death occurred on the date stated above, at 5 30 P.M.
The CAUSE OF DEATH* was as follows:

Bright's Disease

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Woodward M. D.
3/9 1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Concil Idaho	March 9 1920
20. UNDERTAKER	ADDRESS
Glenn C Landon	Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

29799 State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

1. PLACE OF DEATH

County of Payette

City of Payette

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

(No. ..... St.)

File No. .....

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Racheal L Golden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 20 (Day) 1884 (Year)

7. AGE: 35 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: B D Wilson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Jennie Wright

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) ~~O C Sweeter~~ Ethel Clawson

(Address) Payette

15. Filed March 12 1920 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7 1920, to Mar 9 1920 that I last saw h.. alive on Mar 9 1920 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

following Influenza

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J R Woodward M. D.

3/11 1920 (Address) Payette, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL 19.....

20. UNDERTAKER: D M Cidair — ADDRESS Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29800
Registered No.

1. PLACE OF DEATH
County of Payette
City of Fruitland
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora Della Slinker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov 17 (Month) 17 (Day) 1873 (Year)

7. AGE: Yrs. 46 Mos. 3 ds. 26
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: wife ~~Housekeeping~~
(b) General nature of industry, business or establishment in which employed (or employer): Home and children

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Wesley Roberts

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Molly Johnston

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Slinker
(Address) Fruitland Idaho

15. Filed Mar 16 1920 C. C. Paxton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1920 to Mar 14 1920 that I last saw her alive on Mar 14 1920 and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral embolism

(Duration) Yrs. mos. ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) William J Wesse M. D.

3/15 1920 (Address) Ontario, Ore.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL 19

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. Registration District No. [illegible]

County of Payette Primary Registration District No.

City of New Fruitland (No. , Fen Cre St.)

File No. 2961

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pauline Bertha Henggeler

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May 9 1918 (Month) (Day) (Year)

7. AGE: yrs. 22 mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fruitland Ida.

10. NAME OF FATHER: Charles B. Henggeler

11. BIRTHPLACE OF FATHER (State or Country): Conception Mo.

12. MAIDEN NAME OF MOTHER: Agatha Scheeber

13. BIRTHPLACE OF MOTHER (State or Country): Conception Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. B. Henggeler

(Address) Payette R.F.D. #1

15.

Filed Mar 21 1920 C. O. Payton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1920, to Mar 21 1920 that I last saw h.er alive on Mar 20 1920 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Scarlet fever & Measles

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William J Reese M. D.

3/21 1920 (Address) Ontario, Ore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ontario Ore

DATE OF BURIAL: 3/22 1920

20. UNDERTAKER: H L Peterson

ADDRESS: Ontario Ore

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

City of Nampa (No. ..... St.) Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David M, Sheehee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) I9 (Day) 1899 (Year)

7. AGE: 21 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Machanic

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kans.as

10. NAME OF FATHER: P.F.Sheehee

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Sara Chiles ,

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) P.F.Sheehee,

(Address) 623, I4th Ave So. Nampa Idaho

15. Filed April 15 1920 Pearle Dodds Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) - 13 (Day) - 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-13- 1920, to 4-13- 1920, that I last saw h.m alive on 4-13- 1920, and that death occured on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage into pleural cavity - left.

(Duration) 0 Yrs. 5 mos. 1 ds.

Contributory (Secondary) Fracture of clavicle

(Duration 0 yrs. 0 mos. 1 ds.

(Signed) Jno. D. a Kellogg M. D.

19..... (Address) Nampa, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Pioneer Cem — DATE OF BURIAL: 4-15- 1920

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 2983

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 2

County of Ada

Primary Registration District No. 1004

City of Boise (No. 410 State St.)

File No. 18428

Registered No. 177

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delores Esposito

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 1 (Day) 1886 (Year)

7. AGE: 34 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... [redacted] Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Spain

10. NAME OF FATHER Antonio Reta

11. BIRTHPLACE OF FATHER (State or Country) Spain

12. MAIDEN NAME OF MOTHER Martena Erra.

13. BIRTHPLACE OF MOTHER (State or Country) Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Cecilio Esposito

(Address) Vale, Oregon

15. Filed May 10 1920 L. E. Inman Local Registrar

E. R. Collister

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1920, to May 10 1920, that I last saw h[redacted] alive on May 10 1920, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

[redacted] Cancer of Stomach

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Vale, Ore.

19. PLACE OF BURIAL OR REMOVAL: St. Johns Cemetery — DATE OF BURIAL: 5/12 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 29804

Registered No. 127

1. PLACE OF DEATH

County of Ada

City of Boise

(No. St. Alphonsus Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby McWilliams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April - 4 - 1920 (Month) (Day) 1 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: G. B. McWilliams

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Maud Patton

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McBratney

(Address) Boise, Idaho.

15. Filed 4/5 1920 L. O. Gunn, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr - 4 - 1920, 19.....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....19....., to .....19.....,
that I last saw h..... alive on .....19.....,
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Gen. prematurity

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) C. V. Gunn M. D.

4/5 1920 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. ~~LENGTH~~ OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/5 1920

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29805

Registered No. 136

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1064

(No. 410 Hate St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christ Resiotis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. About (Month) (Day) 1890 (Year)

7. AGE About 30 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: Geo. Resiotis

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Katherine Argyropoulos

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Resiotis

(Address)

15. Filed 4/5 1920

L. R. Jones
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 2 1920, to Apr 3 1920, that I last saw h... alive on Apr ... 191..., and that death occured on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Hepatic abscess

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D.R. W. L. Frazier M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 4/5 1920

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29806

Registered No. 168

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 1021, Jefferson St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Della Heed Himrod

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. June (Month) 10 (Day) 1851 (Year)

7. AGE: 68 Yrs. 7 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) St Joseph Buchanan Co. Mo.

10. NAME OF FATHER: Albert Heed

11. BIRTHPLACE OF FATHER (State or Country): U-S-A.

12. MAIDEN NAME OF MOTHER: Mary Bancroft

13. BIRTHPLACE OF MOTHER (State or Country): Buchanan Co. Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) May Himrod

(Address) 1021 Jefferson St.

15. Filed 4/5 1920

L R Forman
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 5th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 3 1920, to Apr 5 1920, that I last saw her alive on Apr 3 1920, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Smith M. D.

4/6 1920 (Address) Boise Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 4/7 1920

20. UNDERTAKER: Schreiber & Liebenfader — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29807
Registered No. 19

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 216 W 7 St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mathan Cohen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October 20 1850 (Month) (Day) (Year)

7. AGE: 59 Yrs. 5 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Poland

10. NAME OF FATHER: Joseph Cohen

11. BIRTHPLACE OF FATHER (State or Country): Poland

12. MAIDEN NAME OF MOTHER: Rebekah Cuppermann

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Isaac Bloch
(Address) Boise Idaho

15. Filed 4/8 1920 L. D. Gorman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1920, to April 8 1920, that I last saw him alive on March 26 1920 and that death occured on the date stated above, at 5:25 P. M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach

(Duration) Yrs. 5 mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) DeWitt B. Higgs M. D.
4-8 1920 (Address) 622 Walnut St

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jewish Cemetery — DATE OF BURIAL: 4/8 1920

20. UNDERTAKER: Schreiber & Hellenthal — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29808

Registered No. 140

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 529 S. 16th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph J Paris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 7th 1920 (Month) (Day) (Year)

7. AGE: ——— Yrs. ——— Mos. ——— ds.

IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: Isaac Paris

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Grace Greenwald

13. BIRTHPLACE OF MOTHER (State or Country): Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace Paris

(Address) Boise, Ida

15. Filed 4/8 1920 L. Hyerman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 7th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 7 1920, to Apr 7 1920, that I last saw h— alive on 4 9 1920, and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Premature birth.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. S. Gregory M. D.

19..... (Address) 1107 N 8th St.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/8 1920

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise, Ida.

Dr. Gregory

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29809
Registered No. 141

Registration District No. 2
Primary Registration District No. 1004

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1901 N 10. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice A Combs
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: July (Month) 12 (Day) 1860 (Year)

7. AGE: 69 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Alice Tuce

13. BIRTHPLACE OF MOTHER (State or Country): Connecticut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J D Combs
(Address) 1901 N. 10th Boise Ida

15. Filed 4/10 1920 L. O. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-12 1920, to 4-7 1920
that I last saw h[illegible] alive on 4-7 1920,
and that death occurred on the date stated above, at 7 44 A.M.
The CAUSE OF DEATH* was as follows:
Organic Heart disease
(Duration) 5 Yrs. mos. ds.
Contributory (Secondary) Influenza
(Duration) yrs. 1 mos. ds.
(Signed) D P Higgs M. D.
4-7 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Apr 10 1920
20. UNDERTAKER: Summers & Krebs
ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

CERTIFICATE OF DEATH

Registration District No. 1004 File No. 2411

City of Boise (No. St Lukes Hospital St.) Registered No. 142

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bessie Hurt.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back o

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sep 11 (Month) (Day) 1857 (Year)

7. AGE: 62 Yrs. 6 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: John R. Gilbert.

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Betsy A. Pettigrew

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Bradford Hurt
(Address): Boise Idaho.

15. Filed 4/10 1920 L. O. Summers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 8 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 - 1920 to apr 8 1920.
that I last saw h.. alive on April 8 1920
and that death occurred on the date stated above, at 12 - M.
The CAUSE OF DEATH* was as follows:
Obstruction of bowel
(Duration) - Yrs. mos. ds.
Contributory (Secondary) Carcinoma
(Duration) yrs. mos. ds.
(Signed) J. D. Springer M. D.
Apr 9 19 20 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dry Creek Cemetery. DATE OF BURIAL: Apr 11 1920

20. UNDERTAKER: Summers & Gebo. ADDRESS: Boise Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No.
Registered No. 29811

1. PLACE OF DEATH
County of Ada
City of Boise (No. 1319 N 14 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew C. Jensen (Jensen)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June 4 (Month) 1873 (Day) (Year)

7. AGE: 46 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stationary Business.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Peter A. Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Christena Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Albert Ritts.
(Address) 1302 E State

15. Filed 4/10 1920 L. P. Ohman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1st 1920 to Apr 6 1920
that I last saw him alive on Apr 6 1920
and that death occurred on the date stated above, at 11:30 M.
The CAUSE OF DEATH* was as follows:
Acute Nephritis following influenza
(Duration) Yrs. 3 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. W. Tallman M. D.
4/9 1920 (Address) Boise-Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Apr 12 1920
20. UNDERTAKER: Summers & Reed — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29812

Registered No. 144

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elena Aburrusa Sillonis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August 13th 1901 (Month) (Day) (Year)

7. AGE: 18 Yrs. 7 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Errendo. Spain

10. NAME OF FATHER: Alejandro Aburrusa

11. BIRTHPLACE OF FATHER (State or Country): Guipuzcoa. Spain

12. MAIDEN NAME OF MOTHER: Mita. Arrasata

13. BIRTHPLACE OF MOTHER (State or Country): Vizcaya Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) A. Sillonis

(Address) Boise. Idaho

15. Filed 4/10 1920 L. P. Quane Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1920, to April 8 1920, that I last saw her alive on April 8 1920, and that death occured on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Septicaemia, due infection on cut on finger

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Neglect of cut finger

(Duration) yrs. mos. ds.

(Signed) L. P. McCalla M. D.

4/9 1920 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Johns Cemetery — DATE OF BURIAL: 4/10 1920

20. UNDERTAKER: Schreiber & Siddenfaden — ADDRESS: Boise. Idaho

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FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29813

Registered No. 145

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jennie May Drake

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 26 (Day) 1886 (Year)

7. AGE: 33 Yrs. 7 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: D. W. Holman

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Mary E. Shacolford

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. W. Drake

(Address) Eagle

15. Filed 4/10 1920

L. P. Summers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 10, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1920 to Apr 10 1920 that I last saw her alive on Apr 10 1920 and that death occured on the date stated above, at 9:30 A. M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of stomach following operation

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Hallman M. D.

4/10 1920 (Address) Boise, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 4/12 1920

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

McCarter

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 23814

Registered No. 147

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410 W. State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel H. Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Oct. 14 1878
(Month) (Day) (Year)

7. AGE: 41 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R R Car inspector
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: M. J. Carter

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Sarah N. Smith

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. E. Carter
(Address) Nampa R. F. D. 2

15. Filed 4/10 1920 L. P. Forman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 10 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1920 to April 10 1920 that I last saw him alive on April 10 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Injuries. Fractures of both femurs & Spine.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) L. P. McCalla M. D.

4/11 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was diseased contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Boise Rest Cemetery DATE OF BURIAL ... 19...

20. UNDERTAKER Summers & Keeler ADDRESS Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

Braxton

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1.04
File No. 29816
Registered No. 149

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 902 Jefferson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John C. Denson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Apr (Month) 12 (Day) 1920. (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many 13 hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Thomas Denson

11. BIRTHPLACE OF FATHER (State or Country): Colorado.

12. MAIDEN NAME OF MOTHER: Opal Wymer.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J C Wymer.
(Address)

15. Filed 4/13 1920 L C Forman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9.15 am Apr 12 1920, to 10 PM Apr 12 1920, that I last saw h. alive on 9 PM Apr 12 1920, and that death occurred on the date stated above, at 10 PM.

The CAUSE OF DEATH* was as follows:
Premature detatchment of Placenta

(Duration) Yrs. mos. 30 min ds.
Contributory (Secondary) Pulmonary atelectasis
(Duration) yrs. mos. 10 hrs ds.

(Signed) J. N. Braxton M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Apr 14 1920.

20. UNDERTAKER: Summers & Cobb. — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29817

Registered No. 150

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 410 State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Herschel Jameson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 21st (Day) 1910 (Year)

7. AGE: 9 Yrs. 8 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nampa Idaho

10. NAME OF FATHER: James Jameson

11. BIRTHPLACE OF FATHER (State or Country): Arkansas.

12. MAIDEN NAME OF MOTHER: Ida Bell Welsch

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Jameson

(Address) 1000 N. 21st Boise

15. Filed 4/15 1920

L. O. Pinman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13 1920, to April 14 1920, that I last saw him alive on April 13 1920, and that death occured on the date stated above, at 3 9 M.

The CAUSE OF DEATH* was as follows:

Abscess of brain

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J. Bond Hill M. D.

4/14/20, (Address) Boise Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 4/16 1920

20. UNDERTAKER: Schreiber & Hedecker | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & ENGRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29818
Registered No. 151

1. PLACE OF DEATH.
County of Ada
City of Boise (No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ervin James Beckman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 25 (Day) 1896 (Year)

7. AGE: 23 Yrs. 4 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Geo. Beckman

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Nellie Greeley

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Leba Beckman
(Address) Burley Ida

15. Filed 4/15 1920
L. P. Jensen
Local Registrar

SYMS - YORK CO., PTRS. & BNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1920 to April 13th 1920, that I last saw h[illegible] alive on April 13th 1920, and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH*, was as follows:
Nephritis, Chronic
Tuberculosis Chronic
Pulmonary
(Duration) 1 Yrs. ✓ mos. ✓ ds.
Contributory (Secondary) ✓
(Duration ✓ yrs. ✓ mos. ✓ ds.

(Signed) J. E. Crouch M. D.
4-13-1920 (Address) Boise Bks Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence ..... Burley Ida

19. PLACE OF BURIAL OR REMOVAL: Burley Ida
DATE OF BURIAL: 4/15 191

20. UNDERTAKER: Schreiber & Hidenfadens
ADDRESS: Boise

Book.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29819
Registered No. 153

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. 1017 Resigue St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Robison
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH: Apr 16 (Month) 16 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. — ds. IF LESS than 1 day how many 5 hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Dewey Robison

11. BIRTHPLACE OF FATHER (State or Country): Oregon.

12. MAIDEN NAME OF MOTHER: Pearl M. Gilbert

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dewey G. Robison
(Address)

15. Filed 4/20 1920 L. R. Rymer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1920 to April 16 1920 that I last saw h. alive on April 16th 1920 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth - (7 months)

(Duration) 2 hours ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Stan Burch M. D.

April 17 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Apr 16 1920

20. UNDERTAKER	ADDRESS
Summers & Kebs.	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29820
Registered No. 154

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 24 Alphonsus St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laverlia Mary Stillwell.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 5 (Month) (Day) 1920 (Year)

7. AGE: ... Yrs. ... Mos. 15 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas. L. Stillwell

11. BIRTHPLACE OF FATHER (State or Country): Boise Idaho

12. MAIDEN NAME OF MOTHER: Mary E. Conway

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. L. Stillwell
(Address) Eagle Idaho

15. Filed 4/20 1920 L. P. Jones Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 5th 1920, to Apr 19th 1920, that I last saw her alive on Apr. 19th 1920, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: -
Pneumonia Post Diphtheritic Croup, Toxic Goitre, Chronic Myocarditis
(Duration) ... Yrs. ... mos. 1 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) L. P. Jones M. D.
Apr 20 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Eagle Idaho — DATE OF BURIAL: Apr 20 1920
20. UNDERTAKER: Summers & Kreb — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29821
Registered No. 155

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 East Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alexander Esson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August (Month) (Day) 1862 (Year)

7. AGE: 57 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: J. Esson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary Dawson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Esson
(Address) Mayfield

15. Filed 4/20 1920 L O Ohman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 20 1920, to April 18 1920, that I last saw him alive on April 12 1920, and that death occured on the date stated above, at 3 a. M.
The CAUSE OF DEATH* was as follows: Carcinoma of Bowels

(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) P P French M. D.
19 (Address) 417 Overland Bldg Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Mayfield Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/20 1920

20. UNDERTAKER: Schreiber & Hidenfelder — ADDRESS: Boise

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STAR-YORK CO., PTRS. & ENGRS. 24653

Dan Tyrrell.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

23822

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 110 E. Bannock St.)

File No.

Registered No. 156

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cortine [redacted] Sanders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 8 (Day) 1893 (Year)

7. AGE: 26 Yrs. 4 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: J. A Sharp

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: Nettie Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. M. Sanders

(Address) Notus Idaho

15. Filed 4/20 1920

L. Forman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 13th 1920, to Apr 20th 1920, that I last saw h[illegible] alive on Apr. 20th 1920, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction - following - Caesarean Operation.

(Duration) ..... Yrs. — mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. M. Taylor M. D.

Apr 20 1920 (Address) C. M. Taylor

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Mountain Grove Mo

19. PLACE OF BURIAL OR REMOVAL: Mountain Grove Mo — DATE OF BURIAL: Apr 22 1920

20. UNDERTAKER: Summers & Trebs — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29823

Registered No. 159

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John F. Sutton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. May (Month) 17 (Day) 1864 (Year)

7. AGE: 55 Yrs. 11 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: William Sutton

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Mahotkinsville

13. BIRTHPLACE OF MOTHER (State or Country): U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John F. Sutton

(Address) 1134 River St Boise

15. Filed 4/23 1920 L. P. Rowe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1920, to April 20 1920, that I last saw him alive on April 20 1920, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Aortic Aneurism

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) D P Higgs M. D.

4/26 1920 (Address) 1626 Wash St Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/22 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Higgs

SYMS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29824

Registered No. 140

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada.

City of Boise

(No. St. Alphonsus Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Edward Eckert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: July 19 1860
(Month) (Day) (Year)

7. AGE: 59 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Guard at
(b) General nature of industry, business or establishment in which employed (or employer): State Penitentiary

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Hiram Eckert.

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Lydia Skeel

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. C. Eckert,
(Address) Boise Idaho.

15. Filed 4/24 1920 L. C. Truax Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 23 - 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 16 1920 to Apr 23 1920 that I last saw h. alive on Apr 23 1920 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Rocky Mountain Fever

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Irving J Pond M. D.

4/25 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 4/26 1920

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, & that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29825

Registered No. 34

1. PLACE OF DEATH

County of Ada

City of Near Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. 2½ miles W of Boise)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clyde J. Gossett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 22 1910 (Month) (Day) (Year)

7. AGE: 9 Yrs. 3 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: B. F. Gossett

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Nora Green

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. F. Gossett

(Address) Boise R.I.

15. Filed Apl 10 1920 L. O. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 9 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from April 9 1920 to ..... 19..... that I last saw h~~im alive~~ died on Apr 9 1920 and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Accidently Killed by Automobile

Skull fractured

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner Ada County

4/9 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Apr 11 1920

20. UNDERTAKER: Summers & Kiebs — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 1956
Registered No. 35

1. PLACE OF DEATH
County of Ada
City of Near Boise
If death occurs away from usual residence, give facts called for under special information.

(No. 1 M. N of Boise St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George A. Brumm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Sept 26, 1880 (Month) (Day) (Year)

7. AGE: 39 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George W. Brumm

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah A. Piatt

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. C. Brumm
(Address) 1015 Main

15. Filed 4/12 1920 L. O. Jenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 11 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased~~ saw from April 11 1920 to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred on the date stated above, at 2.30 M.

The CAUSE OF DEATH* was as follows:
Suicide. Cut throat with razor
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E Summers M.D.
4/12 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic cemetery | DATE OF BURIAL: Apr 13 1920

20. UNDERTAKER: Summers & Hall | ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 29827
Registered No. 29847

1. PLACE OF DEATH
County of Ada
City of Near Boise
(No. 1 mi. S.W. of Boise St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gilbert O. Oberlin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	White	Married

6. DATE OF BIRTH: April (Month) 21 (Day) 1863 (Year)

7. AGE: 56 Yrs. 11 Mos. 22 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate
(b) General nature of industry, business or establishment in which employed (or employer): Dealer

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Clinton Oberlin

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Oberlin
(Address) Boise Idaho

15. Filed 4/15 1920 L. P. Gunnell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1920, to April 13 1920
that I last saw h[illegible] alive on April 12 1920
and that death occurred on the date stated above, at 1130 A.M.
The CAUSE OF DEATH* was as follows:

Venous Thrombosis

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P P French M. D.
Apr 15 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Apr 16 1920
20. UNDERTAKER	ADDRESS
Cummings & Krebs	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2054

File No. 29828

Registered No. 37

1. PLACE OF DEATH

County of Ada

City of

(No. 3 Miles North of Boise)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles H Pidgeon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept 28 (Month) (Day) 1862 (Year)

7. AGE: 57 Yrs. 6 Mos. 21 ds.

IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Solothen Pidgeon

11. BIRTHPLACE OF FATHER (State or Country): N.S

12. MAIDEN NAME OF MOTHER: Angalina Stephens

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Myrtle Reynolds

(Address) Silver Lake Kansas

15. Filed April 22 1920 L. P. Jensen Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1920, to Apr 19 1920, that I last saw h.... alive on Apr 18 1920, and that death occurred on the date stated above, at 8 45 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

+ Intestinal Tuberculosis

.....(Duration) ? Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed) O H Parker M. D.

.....19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Apr 22 1920

20. UNDERTAKER: Summers & Kirks — ADDRESS: Boise Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2004

File No. 29829

Registered No. 538

1. **PLACE OF DEATH**

County of Ada

City of Boise

(No. 1421 Garfield st Boise Ward) (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances Elizabeth Hart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH April 5 1902
(Month) (Day) (Year)

7. AGE 18 Yrs. — Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER I W Hart

11. BIRTHPLACE OF FATHER (State or Country) Conn

12. MAIDEN NAME OF MOTHER Frances Russell

13. BIRTHPLACE OF MOTHER (State or Country) Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr Hart

(Address) Boise, P.O. Box 1399

15. Filed 4/24 1920 L. P. Gunn
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 21 1920 to Apr 22 1920 that I last saw h.. alive on Apr 21 1920 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) / Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Laurence L Glenn M. D.

4/23 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery | DATE OF BURIAL Apr 23 1920

20. UNDERTAKER Summers & Kirk | ADDRESS Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Beach.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29830

Registered No. 39

1. PLACE OF DEATH

County of Ada

City of

(No. 3 miles west of Boise. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James A Hultstrum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June 15 (Month) 15 (Day) 1917 (Year)

7. AGE: 2 Yrs. 10 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John A. Hultstrum

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Gusta Erickson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John A Hultstrum
(Address) Meridian Ida

15. Filed April 24 1920 L. O. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1920 to April 22 1920 that I last saw h.er alive on April 22 1920, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Whooping cough —

(Duration) ..... yrs. 1 mos. 7 ds.

(Signed) John Baird M. D.

April 24 1920. (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Apr. 24. 1920

20. UNDERTAKER: Summers & Stubs. — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 29831
Registered No. 103

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 710 Grove St. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sakae Miyasako.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Yellow
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 24th 1920 (Month) (Day) (Year)

7. AGE: ... Yrs. ... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ...
(b) General nature of industry, business, or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Boise. Ida

10. NAME OF FATHER: S. Miyasako

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Sataka Miyasako

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M Miyasako
(Address) Boise. Ida

15. Filed 4/25 1920 L. B. Thomas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 25th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1920 to April 25 1920, that I last saw h~~im~~ alive on at Kilborn April 25 1920, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Kilborn

..... (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

..... (Duration ... yrs ... mos. ... ds.

(Signed) Lotus Boe M. D.

April 25 1920 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery — DATE OF BURIAL: 4/26 1920

20. UNDERTAKER: Schreiber & Siderfaden — ADDRESS: (Boise)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29832

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Star Ida

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Lawrence.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (If widowed, write the word.): Widowed

6. DATE OF BIRTH. November 9 (Month) (Day) 1839 (Year)

7. AGE: 80. Yrs. ..... Mos. 5 ds. 12

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kentucky.

10. NAME OF FATHER Jacob Loyd

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Nancy Bell.

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jennie D. Lamb.

(Address) Star Idaho

15. Filed Apr 21 1920 A. A. Hall. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 21 (Day) 1920, (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 21 1920, to Apr 21 1920, that I last saw h alive on Apr 21 1920 and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Senility,

..... (Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Weak Heart

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) A. A. Hall M. D.

Apr 21 1920 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemy | DATE OF BURIAL: ..... 191....

20. UNDERTAKER: Shrader Mortuary | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29833

Registered No. 8

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

County of Canyon

City of Cinder Spring

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jay Cinderman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED, WIDOWED~~ OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct (Month) 25 (Day) 1918 (Year)

7. AGE ..... Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Alva C. Cinderman

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Jessie Cull

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alva C. Cinderman

(Address) Cinder Spring Idaho

15. Filed April 29 1920 Ellis Kasey Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1920, to April 14, 1920, that I last saw h~~e~~r alive on April 13 1920 and that death occured on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Bronch

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Peritonitis

(Duration ..... yrs. ..... mos. 14 ds.

(Signed) Ellis Kasey M. D.

April 29 1920 (Address) Cinder Spring Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cinder Spring Idaho | DATE OF BURIAL: April 17 1920

20. UNDERTAKER: Ed Wilkinson | ADDRESS: Cinder Spring

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29834

Registered No. 9

1. PLACE OF DEATH.

County of Canyon

City of Sand Springs

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ray Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (Write the word.)

6. DATE OF BIRTH. Oct. (Month) 25 (Day) 1914 (Year)

7. AGE ..... Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) None

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Abe C. Anderson

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Jennie Ball

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Agnes C. Anderson

(Address) Sand Springs Idaho

15. Filed April 29, 1920 Ellis Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 15, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1920, to April 15 1920, that I last saw her alive on April 14 1920, and that death occured on the date stated above, at 5:10 P.M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..... Yrs. ..... mos. 24 hrs ds.

Contributory (Secondary) Pneumonia

(Duration ..... yrs. ..... mos. 14 ds.

(Signed) Ellis Kinney M. D.

April 1920 (Address) Sand Springs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sand Springs Idaho — DATE OF BURIAL April 17 1920

20. UNDERTAKER Ed Whitman — ADDRESS Sand Springs Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Gifford
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83
Primary Registration District No.
(No. ....., ... St.)

File No. 29835
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis M Lewis.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: January (Month) 15 (Day) 1844 (Year)

7. AGE: 54 yrs. 11 mos. 4 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Richmond Utah

10. NAME OF FATHER: Noriah Lewis

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Martha Youngblood

13. BIRTHPLACE OF MOTHER (State or Country): Alabama.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis Lewis Jr.
(Address) Preston Ida

15.
Filed March 30, 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: January (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1919, to Jan 5 1920, that I last saw h[illegible] alive on Jan 1 1920 and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Renal insufficiency. Uremia
Chronic Nephritis.
Chronic Myocarditis.
(Duration) 2 yrs. mos. ds.
Contributory (Secondary) Cystitis
(Duration) 18 yrs mos ds.

(Signed) C. P. Cutler Jr. M. D.
19 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gifford Idaho | DATE OF BURIAL: Jan 8 1920

20. UNDERTAKER: Irons | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 83

Primary Registration District No. .....

(No. ....., ... St.)

File No. 29836

Registered No. .....

1. PLACE OF DEATH.

County of Bannock

City of Virginia

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin A Tillotson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 3 (Day) 1865 (Year)

7. AGE: 54 Yrs. 5 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): U. S. A.

10. NAME OF FATHER: William A Tillotson

11. BIRTHPLACE OF FATHER (State or Country): U. S. A.

12. MAIDEN NAME OF MOTHER: Caroline Watkins

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edwin Tillotson Jr

(Address) Virginia Idaho

15.

Filed 5-6-1920

H J Boatright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1920, to March 15 1920, that I last saw h... alive on March 9 1920, and that death occured on the date stated above, at 5:10 A M.

The CAUSE OF DEATH* was as follows:

Suicide by Shooting

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) General Poor health

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H J Boatright M. D.

3-16-1920 (Address) Pearsall Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Downey R Fd — DATE OF BURIAL: Mar 18 1920

20. UNDERTAKER: C E Layton — ADDRESS: Downey, Ida.

BYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 83
Primary Registration District No.
(No. , St.)

File No. 29837
Registered No.

1. PLACE OF DEATH

County of Bannock

City of Mc Cammon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl Hecker Parkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 10 (Day) 1892 (Year)

7. AGE: 27 Yrs. 6 Mos. 30 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: J. A. Hecker

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Perlina Norber

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ray Parkinson

(Address) Mc Cammon

15. Filed April 20 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-5-1920, to 2-9-1920, that I last saw her alive on 2-8-1920, and that death occurred on the date stated above, at 2-9-20 8 P.M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary) Miscarriage

(Duration) yrs. mos. ds.

(Signed) H. J. Hartwigsen, M. D.

2-10-1920 (Address) Clearwater, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mc Cammon Ida — DATE OF BURIAL: 2-11-1920

20. UNDERTAKER: R J Hall — ADDRESS: Mc Cammon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 53

File No. 29839

County of Bannock

Primary Registration District No.

Registered No.

City of Mowney (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Franklyn Beckstead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1909 (Year)

7. AGE: ——— yrs. 11 mos. 3 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mowney, Idaho.

10. NAME OF FATHER Percy M. Beckstead

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Leona C. Hutchings

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leona C Hutchings Beckstead
(Address) Mowney, Idaho.

15.
Filed March 30 1920 J H Partridge M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Jan (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920, to Jan 21 1920
that I last saw him alive on Jan 21 1920
and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. 12 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Partridge M. D.

Jan 24 1920 (Address) Mowney Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 11 mos. 3 days. In the State ..... yrs. 11 mos. 3 days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: C E Dowmey — DATE OF BURIAL: Jan 24 1920

20. UNDERTAKER: C E Layton — ADDRESS: Downey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 83

Primary Registration District No. .....

(No. .... St.)

File No. .....

Registered No. 29840

1. PLACE OF DEATH.

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary C Christensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 14 (Day) 1881 (Year)

7. AGE: 39 Yrs. 8 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Hyrum, Utah.

10. NAME OF FATHER John Hartvigsen

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Mary C Thompson

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Rose Christensen

(Address) Downey

15.

Filed 5-6-1920

L. Hartvigsen
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1920, to April 10 1920, that I last saw h.er alive on April 10 1920, and that death occured on the date stated above, at 10:00 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....

.....

(Duration) ..... Yrs. ..... mos. 4½ ds.

Contributory (Secondary) Miscarriage

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. Hartvigsen M. D.

4-7-1920 (Address) Downey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 22 yrs. ..... mos. ..... days. In the State 22 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Downey Idaho — DATE OF BURIAL: April 13 1920

20. UNDERTAKER: C E Layton — ADDRESS: Downey

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29841
Registered No.

1. PLACE OF DEATH

County of Bannock

City of Bancroft

(No. ..... St.)

Registration District No. 84

Primary Registration District No. 2161.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anton Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: March 21st, 1870
(Month) (Day) (Year)

7. AGE: 50 Yrs. Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweeden

10. NAME OF FATHER: Charles J. Peterson

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Mary M. Petersen.

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Hunter (Brother in law)

(Address) Lund Idaho - pm 0th

15. APR 30 1920 Filed ..... 19 .....

O. Kinhurst
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 4th (Month) (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21, 19 20 to April 4th 19 20 that I last saw h. im alive on April 4th 19 20 and that death occurred on the date stated above, at 12.45 noon

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

(Duration) 8 Yrs. ?? mos. ds.

Contributory (Secondary) cardiac asthenia.

(Duration) yrs. mos. 2 ds.

(Signed) O. Kinhurst. M. D.

APR 30 1920 (Address) Bancroft Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lund Idaho	APR 19[illegible]
20. UNDERTAKER family	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29842

Registered No. 3287

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Lava Hot Springs

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sam Richard Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) single

6. DATE OF BIRTH. Feb (Month) 4th (Day) 1920 (Year)

7. AGE ....Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... infant

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Sam Henry Mason

11. BIRTHPLACE OF FATHER (State or Country) Neb.

12. MAIDEN NAME OF MOTHER Jennie Bell

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Sam H. Mason

(Address) Lava Hot Springs Ida

15. Filed Apr 20 1920 O P Street Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 11 1920, to Mar 11 1920, that I last saw h[illegible] alive on Mar 11 1920, and that death occured on the date stated above, at 8-10 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Lobular

.....(Duration) .....Yrs. .....mos. 2 ds.

Contributory (Secondary) Influenza

.....(Duration) .....Yrs. .....mos. 7 ds.

(Signed) O P Henning M. D.

.....19..... (Address) Lava Hot Springs Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs. 1 mos. 7 days. In the State.....yrs. 1 mos. 7 days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lava Hot Springs Ida

DATE OF BURIAL Mar 13 1920

20. UNDERTAKER Lund Home

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOBS. 24854

FORM V. S. No. 5-25 M. 1-19.

29844

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 32
Registered No. 3308

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 340 So. 6 ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. J. Cannon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 25 (Day) 1841 (Year)

7. AGE: 78 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sailor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Stockholm Sweden.

10. NAME OF FATHER: — Cannon

11. BIRTHPLACE OF FATHER (State or Country): Stockholm Sweden

12. MAIDEN NAME OF MOTHER: Charlotte Carlson.

13. BIRTHPLACE OF MOTHER (State or Country): Stockholm Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) May J Cannon
(Address) 340 So. 6th ave

15. Filed May 10 1920 O. B. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 9 1920 to May 9 1920 that I last saw him alive on May 9 1920, and that death occurred on the date stated above, at 6:45 P.M.
The CAUSE OF DEATH* was as follows:

Bronchitis

(Duration) 3 Yrs. 4 mos. ds.
Contributory (Secondary) Pneumonia
(Duration) yrs. mos. ds.

(Signed) H. A. Castle M. D.
May 10" 1920 (Address) Pocatello, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: May 11 1920

20. UNDERTAKER: W. D. Walker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

29845 State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

Registration District No. 84

Primary Registration District No. 2161

File No. 32

Registered No. 3307

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. 941 - No Harrison St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Dewey Hier Jr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: April (Month) 24 (Day) 1920 (Year)

7. AGE: — yrs. — mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Afsy Montana

10. NAME OF FATHER: David D Hier

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Genevieva Martin

13. BIRTHPLACE OF MOTHER (State or Country): McCammon Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A D Martin

(Address) 941 - No Harrison

15. Filed May 10 1920 O R Lloyd Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9-10 A.M. 1920, to May 9-10:30 A.M. 1920, that I last saw him alive on May 9 1920, and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

Weakling - premature

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Malnutrition

(Duration) Since Birth mos. ..... ds.

(Signed) J. P. Lynn M. D.

May 9 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: May 10 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84 — 29846
Primary Registration District No. 2-16
File No. 32
Registered No. 3306

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 460 E. Lincoln St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul A. Tuck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct. 1 (Month) (Day) 18 (Year)

7. AGE: 1 Yrs. 7 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: A. Tuck

11. BIRTHPLACE OF FATHER (State or Country): Grove Port U. S.

12. MAIDEN NAME OF MOTHER: Georgia Summerfield

13. BIRTHPLACE OF MOTHER (State or Country): Winnemucca Nev

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. N. Tuck
(Address) 460 E. Lincoln Ave City

15. Filed May 10th 19 20 O. B. Steele Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1920, to May 6th 1920, that I last saw him alive on May 6th 1920, and that death occurred on the date stated above, at 9:35 A.M.

The CAUSE OF DEATH* was as follows:
Encephalitis
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. 1 mos. 10 ds.

(Signed) H. Arment M. D.
May 10 1920 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: 5/7 1920

20. UNDERTAKER: H. H. Maeser — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

29848

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

File No. 32

County of Bannock

City of Pocatello (No. General Hospital St.)

Registered No. 3 304

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME H. J. McDougal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Unknown (Month) (Day) 1877 (Year)

7. AGE: 43 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) General Hospital
(Address) Pocatello Idaho

15. Filed May 4, 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 19 1920, to May 3 1920 that I last saw him alive on May 3 1920, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Respiratory failure - while under anaesthetic.

(Duration) yrs. mos. ds.

Contributory (Secondary) General Sepsis from osteo-myelitis right Knee.

(Duration) yrs. mos. ds.

(Signed) H. C. Davis M. D.

May 4 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: May 3 1920

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84 — 2984
Primary Registration District No. Pocatello
File No. 32
Registered No. 3303

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Pocatello Hospital St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ivan D. Walker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 6 (Day) 1904 (Year)

7. AGE: 15 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rockland Idaho

10. NAME OF FATHER: W. D. Walker Jr

11. BIRTHPLACE OF FATHER (State or Country): West Weber Utah

12. MAIDEN NAME OF MOTHER: Sarah E. Davis

13. BIRTHPLACE OF MOTHER (State or Country): Bear Lake County Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Walker
(Address) Rockland Ida

15. Filed Apr 27 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/25 1920 to 4/26 1920
that I last saw him alive on 4/26 1920
and that death occurred on the date stated above, at 7:45 P. M.
The CAUSE OF DEATH* was as follows:
~~General Peritonitis~~
Acute appendicitis
Operated 6 days
(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary) General peritonitis
(Duration) yrs. mos. 3 ds.
(Signed) W. F. Havard M. D.
4/27 1920 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ONE days. In the State 15 yrs. 11 mos. 26 days
Where was disease contracted if not at place of death? Rockland Idaho
Former or usual residence Rockland Idaho

19. PLACE OF BURIAL OR REMOVAL: American Falls Ida — DATE OF BURIAL: 4/27 1920

20. UNDERTAKER: W. F. Walker — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 84 — 29850

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 82
Registered No. 3302

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. General Hospital St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Porter D. Hensel

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 13 (Day) 1876 (Year)

7. AGE: 43 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Telegraph Inv.
(b) General nature of industry, business, or establishment in which employed (or employer) ....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: George H. Hansel

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Sophia Martin

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. H. Kemper
(Address) Mansfield Ind.

15. Filed Apr. 28 1920 — O. P. Beers, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1920 to Apr. 25 1920 that I last saw him alive on Apr. 25 191.... and that death occurred on the date stated above, at 9:00 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
Cerebro spinal Syphilis
(Duration) 15 Yrs. .... mos. .... ds.
Contributory (Secondary) ....
(Duration) .... Yrs. .... mos. .... ds.

(Signed) O. B. Peaper M. D.
4-28-1920. (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 9 mos. ....days. In the State ....yrs. 9 mos. ....days
Where was disease contracted if not at place of death? ....
Former or usual residence Ind.

19. PLACE OF BURIAL OR REMOVAL: Terre Haute Indiana — DATE OF BURIAL: Apr 28 1920

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello Ida.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

29851 State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 84

County of Bannock Primary Registration District No. 216

City of Pocatello (No. St Anthonys Hospital St.)

File No. 32

Registered No. 3301

If death occurred away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susanne Wells

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug 27th (Month) (Day) 1872 (Year)

7. AGE: 47 yrs. 5 mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Jacob Schmid

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Barbara Bintner

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Wells
(Address) Mountain View Idaho

15. Filed Apr 25 1920 O B Keel Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 24th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13th 1920, to April 24th 1920, that I last saw her alive on April 26th 1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Embolism Coronary

(Duration) 30 Min. yrs. mos. ds.

Contributory (Secondary) Arteriosclerosis Chronic interstitial nephritis

(Duration) One yrs. mos. ds.

(Signed) W. A. Pettingill M. D.

4/25 1920 (Address) Pocatello, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Idg — DATE OF BURIAL: Apr 29 1920

20. UNDERTAKER: Schumacher & Lee — ADDRESS: Pocatello Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84 29852
Primary Registration District No. 2161
File No. 32
Registered No. 3300

1. PLACE OF DEATH.
County of Bannock
City of 8 miles east of Pocatello (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Hofeldt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH: Mar (Month) 2 (Day) 1920 (Year)

7. AGE: ..... yrs. 1 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bannock Co Idaho

10. NAME OF FATHER: Herman Hofeldt

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Edith Russell

13. BIRTHPLACE OF MOTHER (State or Country): Mo,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edith Russell mother
(Address) Pocatello Idaho

15. Filed Apr 23 1920 O P Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 21, 1920, to Apr 23 1920, that I last saw him alive on Apr 23 1920, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Bronchitis - acute

(Duration) ..... yrs. 1 mos. 15 ds.
Contributory (Secondary) Pertussis
(Duration) ..... yrs. 1 mos. 15 ds.

(Signed) O P Steed, M. D.
Apr 23 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Apr 24 1920

20. UNDERTAKER: none — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 19760

FORM U. S. Nos. 1-12 M. 8-15-12

PLACE OF DEATH

CERTIFICATE OF DEATH

State of Idaho

Registration District No. 246

Primary Registration District No. 2461

Bureau of Vital Statistics

File No. 3 2

Registered No. 3299

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

(No.) General Hospital (Street)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward F. McCabe

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1876 (Year)

7. AGE: 44 Yrs. 5 Mos. 12 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R. R. Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maryland

10. NAME OF FATHER: James McCabe

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Bridget Hogan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) V. Hildegard McCabe
(Address) 526 W. Sublett

15. Filed Mar. 31. 1920 O. R. Steely Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 22 1920 to Mar 30 1920 that I last saw h.. alive on Mar 30 1920 and that death occurred on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Septicaemia.
Strepto-coccus infection.
(Etiology uncertain)

(Duration) .... Yrs. .... mos. 8 .... ds.

Contributory (Secondary)

(Duration) .... Yrs. .... mos. .... ds.

(Signed) O. R. Steely M. D.

Mar 31 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 5 yrs. .... mos. .... days, In the State 5 yrs. .... mos. .... days

Where was disease contracted if not at place of death?

Former or usual residence California

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: Apl 2 1920

20. UNDERTAKER: H. L. McHAN ADDRESS: POCATELLO. IDAHO

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registrar's No. 32

Registered No. 3298

City of Pocatello (No. Tenneal Ranch St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John W. Baldwin

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Colored

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. Not Known (Month) (Day) (Year)

7. AGE About 42 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Pond
(Address) Tenneal Ranch

15. Filed May 3 1920 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 23 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to April 23 1920
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at 6:35 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) [signature illegible] M. D.
April 23 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: May 3 1920

20. UNDERTAKER: H. L. McClain — ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

29855

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. 3297.

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. St. Anthonys Hos St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrews Christjansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	M

6. DATE OF BIRTH. March (Month) 10 (Day) 1878 (Year)

7. AGE 42 Yrs. 1 Mos. 12 ds. IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Denmark Jensen

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Lucena Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Ino

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. P. Jensen
(Address) Blackfoot

15. Filed April 23 1920 J. P. Steele Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1920 to April 22 1920
that I last saw h[illegible] alive on April 22 1920
and that death occurred on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:
Septicaemia
.....
.....
.....(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Senile atrophy Media
.....(Duration) ..... Yrs. ..... mos. 18 ds.

(Signed) [illegible] M. D.
April 23 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Blackfoot Ida. DATE OF BURIAL April 23 1920

20. UNDERTAKER H. L. McClain ADDRESS Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Dr Roop

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

29856

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 216

File No. 32

County of Bannock

City of Pocatello (No. 892 N. Garfield St.)

Registered No. 3296

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Southank

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Feb 15th 1825 (Month) (Day) (Year)

7. AGE: 95 yrs. 2 mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Jas Southank

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Margaret Gorman

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dana Robison
(Address) #892 N. Garfield

15. Filed Apr 22 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 22nd 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920 to April 21 1920 that I last saw him alive on April 9 1920 and that death occurred on the date stated above, at 7:30 Am

The CAUSE OF DEATH* was as follows: Capillary Bronchitis

(Duration) yrs. / mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John F. Rapp M. D.

April 21/1920 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Apr 25 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

29857

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 32
Registered No. 3295

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 402 No 3 ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Reed.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: Colored.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan 5. (Month) (Day) 1899. (Year)

7. AGE: 21 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas City Kas

10. NAME OF FATHER: Richard Reed.

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: ~

13. BIRTHPLACE OF MOTHER (State or Country): Kansas City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Josephine De Gans.
(Address) 402 No 3 ave.

15. Filed Apr 22 1920 O. B. Steed, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April. (Month) 22. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1920, to April 21 1920, that I last saw him alive on April 21 1920, and that death occurred on the date stated above, at 7 30 A.M.

The CAUSE OF DEATH* was as follows:
Diphtheria

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Toxemia
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. B. Arnott M. D.
Apr 22 1920 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cemetery — DATE OF BURIAL: 4/23 1920

20. UNDERTAKER: Mumaw, Lee. — ADDRESS: Pocatello Ida

Dr Arnott.

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

29858

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3294

Registration District No. 84
Primary Registration District No. 216
(No. General Hospital, Pocatello)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock
City of Pocatello

2. FULL NAME Irene Louise Sparks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. May 19 1900
(Month) (Day) (Year)

7. AGE: 20 Yrs. 5 Mos. 9 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk Dentists office
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Clarence Sparks

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Nellie Currie

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Maude Kenkaid
(Address) Eugene Oregon

15. Filed April 22 1920 — Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1920 to April 21 1920
that I last saw her alive on April 21 1920
and that death occurred on the date stated above, at 12 20 A. M.

The CAUSE OF DEATH* was as follows: Pneumonia with pleurisy

(Duration) .... Yrs. .... mos. 8 .... ds.

Contributory (Secondary)

(Duration) .... Yrs. .... mos. .... ds.

(Signed) John J. Cao M. D.
April 22 1920. (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. 8 days. In the State ....yrs. 6 mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence Eugene Oregon

19. PLACE OF BURIAL OR REMOVAL: Mt View Pocatello — DATE OF BURIAL: Apr 23 1920

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH 29859

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3293

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. Millnickal mine 4 miles S.E. of Pocatello upon hills)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isa Dodge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH. Nov 27 1 (Month) (Day) (Year)
7. AGE: 61 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many .... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Wisconsin
10. NAME OF FATHER: Thomas Dodge
11. BIRTHPLACE OF FATHER (State or Country): New York
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (State or Country): New York
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Irene Dodge
(Address) 876 Washington ave. Harriman Addition
15.
Filed April 7 1920 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: found April 6. 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at Not Known M.
The CAUSE OF DEATH* was as follows:
Accidental discharge of grant caps
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) S D Ferguson Coron M. D.
4/7/1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 4 yrs. in mos. days, In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? .....
Former or usual residence Wyoming

19. PLACE OF BURIAL OR REMOVAL: Kemmerer Wyoming — DATE OF BURIAL: April 8. 1920
20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH 29860

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3292.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 84
Primary Registration District No. 21 41

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. Sunset Hosp. St.)

2. FULL NAME Wayne Lillibridge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH. May 31 1920
(Month) (Day) (Year)

7. AGE ____ Yrs. ____ Mos. 3 ds. | IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... none
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) Pocatello, Ida

10. NAME OF FATHER Abe Lincoln Lillibridge

11. BIRTHPLACE OF FATHER (State or Country) Pocatello, Ida

12. MAIDEN NAME OF MOTHER Ethel Folson

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Abe Lincoln Lillibridge
(Address) 1316 N. Garfield ave.

15. Filed April 3. 1920 O. B. Steely Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 2 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920 to April 2 1920
that I last saw him alive on April 2 1920
and that death occurred on the date stated above, at 9. P. M.

The CAUSE OF DEATH* was as follows:
Foetal Atelectasis
(Duration) ... Yrs. ... mos. 2 ds.
Contributory (Secondary) Premature birth
(Duration) ... Yrs. ... mos. 2 ds.

(Signed) A. M. Newton M. D.
Apr. 3 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days Life
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mt View Cemetery — DATE OF BURIAL Apr. 3. 1920

20. UNDERTAKER H. L. McClain — ADDRESS Pocatello Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

29861 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3291
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 54
Primary Registration District No. 2161
(No. 835 So. Hanson St.)

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Norma Betsy Burns

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 6. (Day) 1919 (Year)

7. AGE — Yrs. 10 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: J. R. Burns

11. BIRTHPLACE OF FATHER (State or Country): Ottawa Canada

12. MAIDEN NAME OF MOTHER: Jora Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Pocatello Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Burns
(Address) 835 So. Hanson

15. Filed Apr 7, 1920 [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 31 1920 to Apr 2nd 1920
that I last saw h.....alive on Apr. 2nd 1920
and that death occurred on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:
Acute Lobar Pneumonia
Edema of Lungs
Convulsions
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
1920 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? Pocatello
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View — DATE OF BURIAL: April 4 1920

20. UNDERTAKER: H. L. McClain — ADDRESS: Pocatello

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

29862

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

File No. 32

County of Bannock

City of Pocatello (No. 1324 N. 2nd St.)

Registered No. 3290

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eric Drexel Sykes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: April (Month) 17 (Day) 1920 (Year)

7. AGE: one half hour — yrs. mos. ds.

IF LESS than 1 day how many ½ hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho. 1324 No 2nd

10. NAME OF FATHER: John D. Sykes

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Edith M woodell

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno D Sykes
(Address) 1324 No 2nd

15. Filed Apr 18 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1920 to April 17 1920 that I last saw her alive on April 17 1920 and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:

Abnormal large baby forceps delivery premature (Delyd delivery)

(Duration) yrs. mos. ds.

Contributory (Secondary) premature birth.

(Duration) yrs. mos. ds.

(Signed) J H Sykes M. D.

April 17 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] Cemetery — DATE OF BURIAL: 4 18 1920

20. UNDERTAKER: [illegible] Walker — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

D. Young 19867

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

File No. 32

County of Bannock

City of Pocatello (No. St Anthony Hospital (St.)

Registered No. 3289

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Miss Frances Einluger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 21st 1891 (Month) (Day) (Year)

7. AGE: 29 yrs. mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Frank Einluger

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Mary Leadermer

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis Einluger
(Address) American Falls Idaho

15. Filed Apr 28 1920 P B Steel Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr 17th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/14/1919, to 4/17/1920, that I last saw her alive on 4/16/1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Laryngeal Tuberculosis

(Duration) yrs. 1 mos. ds.

Contributory (Secondary) Laryngeal Tuberculosis

(Duration) 3 yrs. 1 mos. 15 ds.

(Signed) [illegible] M. D.

4/29 1920 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Apr 20 1920

20. UNDERTAKER: Chamberlain & Hay — ADDRESS: Pocatello

Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

84 29864

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No.

County of Bannock Primary Registration District No. 2161 File No. 32

City of Pocatello (No. Residence S. Main St.) Registered No. 3288

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth J Von Stein

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: April 12 (Month) 1 (Day) 1849 (Year)

7. AGE: 71 yrs. 1 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: David Evans

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Amy J. Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. D. J. Stair
(Address) Pocatello Ida

15. Filed Apr 16 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr 16 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1919, to Apr 16 1920 that I last saw her alive on Apr 15 1920 and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis

(Duration) 1 yr. mos. ds.

Contributory (Secondary) Diabetes of Heart

(Duration) yrs. 6 mos. ds.

(Signed) J. F. Miller M. D.
4/16 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lawrence Barn | DATE OF BURIAL: Apr 19 1920

20. UNDERTAKER: Schumacher Bros | ADDRESS: Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19

CERTIFICATE OF DEATH

29865

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2nd
File No. 32
Registered No. 3287

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. 1006 - So 5th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phyllis Irene Overdorf
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: July (Month) 30 (Day) 1918 (Year)

7. AGE: 1 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: W. A. Overdorf

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Ethel Holly

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Overdorf
(Address) Pocatello

15. Filed Apr 15 1920 O. B. Healy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 7th 1920, to Apr 14 1920
that I last saw her alive on Apr 14 1920,
and that death occurred on the date stated above, at 8 7m P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia acute Bronchial.

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Nephritis Chronic Interstitial
(Duration) ..... yrs. 5 mos. ..... ds.
(Signed) W. W. Brothers M. D.
4/15 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: Apr 16 1920

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84 — 29866

Primary Registration District No. Lincoln — File No. 32

Registered No. 3286

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. Lundy Subdivision St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Ray

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

(Month) (Day) (Year) 1860

7. AGE 60 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) ✓

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. L. Warner

(Address) County Supervisor

15. Filed Apr 12 1920 O. R. Street Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

(Month) Apr. (Day) 9th 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1st 1920 to Apr. 11 1920

that I last saw h. alive on Apr. 11 1920

and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. S. Warner M. D.

Apr 11 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Pocatello — DATE OF BURIAL 4-13 1920

20. UNDERTAKER T. J. Allen — ADDRESS Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of St Charles
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 33
Primary Registration District No. ~~33~~ 2182
(No. ....., ... St.)

File No. 29867
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephine Mattson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1847 ~~1848~~ (Year)

7. AGE: 73 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Malma Sweden

10. NAME OF FATHER: dont know

11. BIRTHPLACE OF FATHER (State or Country): Smoland Sweden

12. MAIDEN NAME OF MOTHER: dont know

13. BIRTHPLACE OF MOTHER (State or Country): Helsenburg Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Emma Stewart
(Address): St Charles

15.
Filed May 13 1920 John Mattson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1920 to April 5th 1920
that I last saw her alive on April 5th 1920
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Dalton M. D.
4/12 1920 (Address) Paris Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: St Charles Id. DATE OF BURIAL: April 13 1920

20. UNDERTAKER: John Mattson ADDRESS: St Charles

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29868

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 33
Primary Registration District No. ~~2~~ 2132
(No. ....., ... St.)

Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John A. Blade

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Sept (Month) 12 (Day) 1862 (Year)

7. AGE: 37 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rundsval Sweden

10. NAME OF FATHER: Blade

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: dont known

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Josephine C Blade
(Address) St Charles Id.

15.
Filed May 18 1920 John Mattson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) ~~10~~ 13. (Day) ~~1862~~ 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1919 to May 10 1920
that I last saw him alive on May 10 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Pneumonia R Pleurisy

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
May 13 1920 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles Id. DATE OF BURIAL: April 19 1920

20. UNDERTAKER: John Mattson ADDRESS: St Charles

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No.
File No. 23869
Registered No. 7

1. PLACE OF DEATH
County of Bonneville
City of Worley
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy David

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1906 (Year)

7. AGE: 14 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lived with her parents
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bonneville, Idaho

10. NAME OF FATHER: George David

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Ellen

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): George David
(Address): Worley Idaho

15. Filed April 6 1920
J. L. Bidwell
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 30 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,
that I last saw h.... alive on ....19....,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
Miscarriage
No physician's certificate
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
19.... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonneville — DATE OF BURIAL: April 6, 19 20

20. UNDERTAKER: J. Falconer — ADDRESS: Bonneville

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No.
File No. 29871
Registered No. 9

1. PLACE OF DEATH
County of Benewah
City of Vernet
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Burke
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: 2 (Month) 20 (Day) 1 (Year)

7. AGE: Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nezperces Ida.

10. NAME OF FATHER: William Burke

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Josette Garrick

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jos Garrick
(Address): Vernet

15.
Filed April 1 1920
J. L. Bilhans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 31 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Pneumonia
Attended by Dr J. G. Nelson
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
19..... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Vernet — DATE OF BURIAL: April 2 1920

20. UNDERTAKER: J. Falcon — ADDRESS: Vernet

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31

Primary Registration District No.

File No. 29872

Registered No. 70

1. **PLACE OF DEATH**

County of Benewah

City of Tensed (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** John Ignace

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	Indian	Infant

6. **DATE OF BIRTH** April 14 (Month) (Day) 1920 (Year)

7. **AGE** ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ½ hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Tensed

10. **NAME OF FATHER** John Ignace

11. **BIRTHPLACE OF FATHER** (State or Country) Idaho

12. **MAIDEN NAME OF MOTHER** Elizabeth

13. **BIRTHPLACE OF MOTHER** (State or Country) Idaho

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) John Ignace

(Address) Desmet

15. Filed April 15 1920 J. L. Bihan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** April 14 (Month) (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

No Physician Attended

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Desmet	April 15 1920
20. UNDERTAKER J. Falcon	**ADDRESS** Desmet

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31

Primary Registration District No.

File No. 29873

Registered No. 11

1. PLACE OF DEATH

County of Benewah

City of Deary

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gertrude Matilda Roth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Nov (Month) 16 (Day) 1918 (Year)

7. AGE: 1 Yrs. Mos. 3 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Benewah Co Idaho

10. NAME OF FATHER: Victor Roth

11. BIRTHPLACE OF FATHER (State or Country): Benewah Co Ida

12. MAIDEN NAME OF MOTHER: Tarsa Mary Joseph

13. BIRTHPLACE OF MOTHER (State or Country): Round Alene Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Victor Roth

(Address) Deary Ida

15.

Filed April 28 1920

J. Le Bihan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 28 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 25 1920, to Apr 28 1920, that I last saw h[illegible] alive on Apr 27 1920, and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows: Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. A. Nelson M. D.

4/28 1920 (Address) Deary Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Dr Sweet, Ida, — DATE OF BURIAL: April 29 1920

20. UNDERTAKER: none but Self. — ADDRESS: Deamer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 29875
Registered No. 75

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Benewah
City of St Maries

2. FULL NAME Edward C Seward

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Oct (Month) 15 (Day) 1871 (Year)

7. AGE
48 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R R Man
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER: Robert Seward

11. BIRTHPLACE OF FATHER
(State or Country) D K.

12. MAIDEN NAME OF MOTHER: Mary Scott

13. BIRTHPLACE OF MOTHER
(State or Country) D K.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs E C Seward
(Address) St Maries

15.
Filed April 24 1920
H E Hunt
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 19 1920, to Apr 24 1920, that I last saw h alive on Apr 19 1920, and that death occured on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:
Cirrhosis of Liver

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) C B Smith M. D.
4/24 1920 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wood Lawn
DATE OF BURIAL: 4/25 1920

20. UNDERTAKER: H E Hunt Co
ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3 2
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 23876
Registered No. 17

1. PLACE OF DEATH.
County of Benewah
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida May Swope

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 27 (Day) 1856 (Year)

7. AGE: 63 Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Providence R I

10. NAME OF FATHER: Jerry Kittle

11. BIRTHPLACE OF FATHER (State or Country): R. I.

12. MAIDEN NAME OF MOTHER: Mary Bennet

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lynel Swope
(Address) St. Maries

15. Filed April 21 1920 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 17 1920, to Apr. 17 1920, that I last saw h[illegible] alive on X 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Valvular heart disease and over exertion.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. Salem Coroner M. D.
April 21 19 20 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Mitchell & Meraga
ADDRESS: St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO. PTRS. & STNRS. 24953

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29877

Registered No. 13

Registration District No. 39

Primary Registration District No. 2049

(No. ..... , ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

City of St. Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Juliet E. Keating

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. April (Month) 20 (Day) 1850 (Year)

7. AGE: 69 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New Orleans

10. NAME OF FATHER: Thomas Murphy

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elleck Davis

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Virginia McCray

(Address) St. Maries Idaho

15.

Filed April 20 1920

H E Ernst
Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1920, to Apr 16 1920, that I last saw h[illegible] alive on Apr 16 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Bonwell M. D.

4/20 1920 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn | DATE OF BURIAL: Apr. 20 1920

20. UNDERTAKER: Mitchell & Merogis | ADDRESS: St. Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29878

Registered No. 12

Registration District No. 32

Primary Registration District No. 2049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Ranch

2. FULL NAME Ezra DeForest Titus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 15 (Day) 1858 (Year)

7. AGE: 62 Yrs. — Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Ills.

10. NAME OF FATHER: Orson Titus

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Nancy Spencer

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Margaret Titus
(Address) St Maries

15. Filed April 19 1920 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 18 1920, to Apr 18 1920, that I last saw h[illegible] alive on Apr 18 1920, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 1 hr ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. Colorwall M. D.

4/19 1920 (Address) St. Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 4/20 1920

20. UNDERTAKER: H E Hunt Co. — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2173
(No. ....., ... St.)

File No. 29880
Registered No. 8

1. PLACE OF DEATH.
County of Bonner
City of Plummer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudolph Grunewald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. (Month) Dont Know (Day) ..... (Year) .....

7. AGE: about 60 yrs. ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Labor
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. D. Jurgen
(Address) Plummer

15. Filed Apr 6 1920 — W. D. Jurgen, Local Registrar

SYMS-YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1920, to Apr 5 1920, that I last saw him alive on Apr 5 1920, and that death occured on the date stated above, at 10½ P.M.

The CAUSE OF DEATH* was as follows:
Aneurism
(Duration) 2 Yrs. — mos. — ds.
Contributory (Secondary) Arteriosclerosis
(Duration 2 yrs. — mos. — ds.

(Signed) H. W. Dickie M. D.
6 1920 (Address) Plummer Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plummer, Idaho — DATE OF BURIAL: Apr. 11 1920

20. UNDERTAKER: W. D. Jurgen — ADDRESS: Plummer

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2172
File No. 29881
Registered No. 9

1. PLACE OF DEATH.
County of Benewah
City of Near Plummer (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Grant Morgan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 28 (Day) 1864 (Year)

7. AGE: 55 Yrs. 8 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Labour
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maysville, Decatur Co. Missouri

10. NAME OF FATHER: Simeon Morgan

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Eliza Ogal

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. F. Morgan
(Address) Chatcolet, Idaho.

15. Filed Apr 28 1920 — W. L. Jaques, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1920, to Apr 26 1920, that I last saw h[illegible] alive on Apr 20 1920, and that death occured on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemmorhage

(Duration) Yrs. mos. 13 ds.
Contributory (Secondary) Had two Strokes previous.
(Duration yrs. mos. ds.

(Signed) Owen D. Pell M. D.
Apr 28 1920 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plummer, Idaho — DATE OF BURIAL: Apr. 28 1920

20. UNDERTAKER: W. L. Jaques — ADDRESS: Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2172
File No. 29882
Registered No. 7

1. PLACE OF DEATH.
County of Benewah
City of near Plummer (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Not known (Month) (Day) (Year)

7. AGE: 67 (about) Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Peter Johansson

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. Peterson
(Address) Plummer

15. Filed May 17 1920 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis
.....
.....
(Duration) 10 Yrs. — mos. — ds.
Contributory (Secondary) Angina Pectoris
(Duration no yrs. 3 mos. — ds.
(Signed) H. W. Dodier M. D.
Apr. 3 1920 (Address) Plummer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Plummer. DATE OF BURIAL: Apr. 8 1920

20. UNDERTAKER: H. Jorgen ADDRESS: Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BKRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. #16

Primary Registration District No. 2195

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29883

Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Aberdeen

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Claasen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 9 (Day) 1920 (Year)

7. AGE: 0 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George Claasen

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Martha Roose

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. J. Olsen

(Address) Aberdeen Falls Ida

15. Filed Apr 15 20 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 7 1920, to Apr 10 1920, that I last saw him alive on Apr 7 1920, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Marasmus - Unable to digest food Probably

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 1 yrs. 1 mos. ..... ds.

(Signed) C. J. Schick M. D.

4/10 1920 (Address) Aberdeen Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: German Lutheran Cemetery — DATE OF BURIAL: Apr 12 1920

20. UNDERTAKER: Family — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 29884
Registered No. 27

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Grayden Rhodes

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec 2 (Month) (Day) 1920 (Year)

7. AGE: Yrs. 4 Mos. — ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wesley Rhodes

11. BIRTHPLACE OF FATHER (State or Country): South Dakota

12. MAIDEN NAME OF MOTHER: Bennie Bacon

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. E. Bacon
(Address) Aberdeen Ida

15. Filed Ap 2 20 [illegible] 191.....
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Ap. (Month) 2 (Day) 20 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Ap 1 20 191..., to Ap 2 20 191...,
that I last saw h[illegible] alive on Ap 1 20 191...,
and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Enlarged Thymus gland.
Died suddenly

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. C. Mortensen M. D.
Ap 2 20 19..... (Address) Aberdeen Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I. O. O. F. Cemetery Aberdeen Idaho
DATE OF BURIAL: Ap 4 20 191.....

20. UNDERTAKER: Friends
ADDRESS

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (b) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

2 H 6

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 116

Primary Registration District No. 2185-

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29885

Registered No. 25

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Aberdeen

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Jantzen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Apr (Month) 22 (Day) 1903 (Year)

7. AGE: 16 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: John Jantzen

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Claassen

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): John Jantzen
(Address): Idaho Falls Ida

15. Filed Apr 2 20 1920 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Contagion - was dead when first seen by me. Fell over dead in field had complained of pain in chest, (Duration) ..... yrs. irregular heart mos. ..... ds.
Contributory (Secondary) heat during day
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Selgitz M. D.
9/7 1926 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mennonite cemetery nee Aberdeen — DATE OF BURIAL: April 6 1920

20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 29886
Registered No. 54

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot (No. 89 Jensen St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elmer Dodge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. April (Month) (Day) 1893 (Year)
7. AGE: 27 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer): Auto
9. BIRTHPLACE (State or Country): Utah.
10. NAME OF FATHER: R.A. Dodge
11. BIRTHPLACE OF FATHER (State or Country): Glenwood Utah
12. MAIDEN NAME OF MOTHER: Agnes Jones
13. BIRTHPLACE OF MOTHER (State or Country): England.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Maud Dodge
(Address) Blackfoot
15. Filed Feb - 19 1920 Mrs Nellie E. Palmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1920, to Feb 18 1920, that I last saw him alive on Feb 18 1920, and that death occured on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Influenza.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Complications
(Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) W J Summers M. D.
Feb 18 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fem city cemetery — DATE OF BURIAL ..... 191...
20. UNDERTAKER: E J Puck — ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYNS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29887

Registered No. [illegible]

1. PLACE OF DEATH

County of Bingham

City of Thomas Prec't.

(No. ..... St.)

Registration District No. 121

Primary Registration District No. 1217

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Palmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 28 (Day) 920 (Year)

7. AGE: 0 Yrs. 0 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Thomas Idaho

10. NAME OF FATHER: James T Palmer

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Meada Boice

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James T Palmer

(Address) Thomas Ida

15. Filed 4-1 1920 Wm. Marie E. Pettit Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated

deceased 19 ..... to April 1 19 20

~~that I last saw him~~ ..... alive on ..... 19 ....., and that death occurred on the date stated above, at 6 P.C. M.

The CAUSE OF DEATH*, was as follows:

Convulsions, cause unknown

(2 Convulsions)

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Pettit M. D.

4/1/1920 (Address) Co Health Officer Blackfoot Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside Cem. DATE OF BURIAL: Apr 2 1920

20. UNDERTAKER: Ed L Eyl ADDRESS: Blackfoot

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... St.)

File No. 29888

Registered No. 5-6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha May Pierce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH

June (Month) 11 (Day) 1884 (Year)

7. AGE

35 Yrs. 9 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER James Baird

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. E. Pierce

(Address) Blackfoot Idaho

15.

Filed ..... 19 ..... Mollie E. Pierce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1920 to March 31 1920

that I last saw her alive on March 31 1920

and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Humphrey M. D.

4/21 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fairview Cemetery	April 4 1920
20. UNDERTAKER E. J. Funk	ADDRESS Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 29889
Registered No. 7

1. PLACE OF DEATH
County of Bingham
City of Blackfoot, (No. R F D 3 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph S Swanbauer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 16 1857 (Month) (Day) (Year)

7. AGE: 62 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bohemia

10. NAME OF FATHER: Andrew Swanbauer

11. BIRTHPLACE OF FATHER (State or Country): Bohemia.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph S Swanbauer
(Address) Blackfoot Idaho.

15. Filed ..... 1926 Mrs Lucia F Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 2d 1926 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31 1926, to April 2d 1926
that I last saw him alive on April 2d 1926.
and that death occurred on the date stated above, at 5.30 P.M.
The CAUSE OF DEATH* was as follows:

myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bronchitis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Summerson M. D.
4/3 1926 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Town cemetery
DATE OF BURIAL: 4-6 1926

20. UNDERTAKER: E J Funk
ADDRESS: Blackfoot

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 29890
Registered No. 5-8

1. PLACE OF DEATH. Registration District No. 121
County of Bingham Primary Registration District No. 2194
City of Blackfoot (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Freant

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ____ (Month) ____ (Day) 1865 (Year)

7. AGE: 55 yrs. — mos. — ds. — IF LESS than 1 day how many ____ hrs. or ____ min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Can't say

11. BIRTHPLACE OF FATHER (State or Country): Can't say

12. MAIDEN NAME OF MOTHER: Can't say

13. BIRTHPLACE OF MOTHER (State or Country): Can't say

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Undertaker Roberts
(Address) Blackfoot, Ida.

15. Filed April 5 1920 Mrs Rubie E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1919, to 4-5 1920
that I last saw h[illegible] alive on 4-5 1920
and that death occurred on the date stated above, at 6.30 P. M.

The CAUSE OF DEATH* was as follows:
Expansion of General Paralysis

(Duration) ____ yrs. 1 mos. 12 ds.
Contributory (Secondary) Inguinal tumor, probably [illegible]
(Duration) 1 yrs. — mos. — ds.

(Signed) C. A. Brown M. D.
4-5 1920 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ ds. In the State of Idaho yrs. 4 mos. 5 ds.
Where was disease contracted, if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Roberts Ida
DATE OF BURIAL: ____ 191

20. UNDERTAKER: Jeff Hayes
ADDRESS: Idaho Falls Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29891

Registered No. 59

1. PLACE OF DEATH.

County of Bannock

City of Thomas Brach

Registration District No. 121

Primary Registration District No. 214

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lydia Ganske

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 29 (Day) 1906 (Year)

7. AGE: 13 Yrs. 6 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Michael Ganske

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Christina Zorak

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs F Miller

(Address) Blackfoot Idaho Route 2

15. Filed April 4th 1920 Mrs Nadine E. Pubre Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 4th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1920, to Mar 28 1920, that I last saw her alive on Mar 28 1920, and that death occured on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Disease Heart-

Mitral

(Duration) 6 Yrs. mos. ds.

Contributory (Secondary) Intestinal Nephritis

Chronic

(Duration) 1 yrs. 6 mos. ds.

(Signed) W. E. Pettis M. D.

March 9th 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Idaho — DATE OF BURIAL: April 11 1920

20. UNDERTAKER: Gosting & Son — ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24656

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121

Primary Registration District No. 1007

File No. 29892

Registered No. 60

1. PLACE OF DEATH.

County of Bingham

City of Blackfoot

(No. Blackfoot Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Elsa Bentley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 6 (Day) 1875 (Year)

7. AGE: 44 Yrs. 10 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Frank Brooks

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Polly Gonce

13. BIRTHPLACE OF MOTHER (State or Country): Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Samuel Bentley
(Address) Blackfoot Route 4

15. Filed April 13 1920 Mo Nalin E. Pabst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 29 1920, to April 13 1920, that I last saw her alive on April 13 1920, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Cholecystitis and Cholecystonecus with blood and Pus

(Duration) Yrs. 4 mos. 0 ds.

Contributory (Secondary) Appendicitis acute Cholecystostomy and Appendectomy

(Duration) Yrs. mos. 7 ds.

(Signed) D. E. Pabst M. D.

4/13 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Idaho — DATE OF BURIAL: April 14 1920

20. UNDERTAKER: E. J. Peck — ADDRESS: Blackfoot Idaho

STUB - YORK CO., PTRS. & PUBS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 29894
Registered No. 62

1. PLACE OF DEATH
County of Bingham
City of Shelley R.D. #2
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME x Ronald Just
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 19 (Day) 1920 (Year)

7. AGE: ... Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... / ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Leslie Just

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Francis Cassidy

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) x James Just
(Address) Shelley R 2

15. Filed 4-20 1920 Mrs Nelie E. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1920, to April 19 1920 that I last saw h.im alive on April 19 1920 and that death occurred on the date stated above, at 10:15 A.M.

The CAUSE OF DEATH* was as follows:

Premature birth
6½ mo
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) W W Beck M. D.
4/20 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lincoln Cemetery | DATE OF BURIAL: April 21 1920

20. UNDERTAKER: E J Funk | ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 29895
Registered No. 63

1. PLACE OF DEATH

Registration District No. 121
Primary Registration District No. 2194

County of Bingham
City of Moreland Precinct (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl August Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: August (Month) 16 (Day) 1842 (Year)

7. AGE: 77 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrus Peterson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Peterson
(Address) Moreland Ida.

15. Filed 4-28 1920 Mrs Helen E. Patrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ ~~visited~~ deceased from death, 19..., to Apr 28 1920
that I last saw he alive on May 15 1918
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH*, was as follows:
Pneumonia Lobar - both Lungs
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Arterio sclerosis
(Duration) 10 Yrs. ..... mos. ..... ds.
(Signed) W. E. Patrie M. D.
4/28 1920 (Address) Blackfoot Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Cemetery — DATE OF BURIAL: Apr 29 1920

20. UNDERTAKER: Ed L. Ogle — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 29896
Registered No. 64

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dora Price

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 27 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 9 hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charles Henry Price

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Lizzie Leora Jones

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Price
(Address) By A. R. Knight

15. Filed 4-28 1920 Blackfoot, Idaho
Mrs. Julia E. Patrick
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1920, to April 27 1920, that I last saw h.er alive on April 27 1920, and that death occurred on the date stated above, at 1:45 P. M.

The CAUSE OF DEATH* was as follows:

Hydrocephalis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Beck M. D.

4/28 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fem Cem Bingham County
DATE OF BURIAL: 4 28 1920

20. UNDERTAKER: E. T. Rich
ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-19.

Page

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 29899
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matt Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 20 (Day) 1881 (Year)

7. AGE: 38 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cedar maker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Anderson
(Address) Sammels Ida

15. Filed May 8 1920 FLOYD G. WENDLE Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10. 1920 to March 19 1920 that I last saw him alive on March 19 1920, and that death occurred on the date stated above, at 4.05 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia (Unilateral)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Payne M. D.

..... 19..... (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida
DATE OF BURIAL: 3/20 1920

20. UNDERTAKER: Ernest Bower
ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of [redacted]
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2137
File No. 23998
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Leonard Tholborg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Jan (Month) 5 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: N. G. Tholborg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ellen Berglund

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. G. Tholborg
(Address) Sandpoint Ida

15. Filed May 8 1920 FLOYD G. WENDLE Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1920, to Jan 17 1920, that I last saw him alive on Jan 15 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Congenital Malformation of Heart
(Duration) ..... Yrs. ..... mos. 17 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Page M. D.
1920 (Address) Sandpoint Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida	1/18 1920
20. UNDERTAKER: Ed Brown	ADDRESS: S. P.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2 1 5 5
(No. ..... , ... St.)

File No. 30000
Registered No. .....

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Lidiza Glasgow
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Apr. (Month) 4 (Day) 1867 (Year)

7. AGE: 57 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Henry Bodinus.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. N. Glasgow
(Address) Sandpoint, Ida.

15. Filed May 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1920, to March 28 1920, that I last saw her alive on March 28 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Endocarditis
(Duration) Indefinite yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia.
(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) O. R. Gayer M. D.
April 3 1920 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Apr 20 1920
DATE OF BURIAL: .....

20. UNDERTAKER: E. M. Brower.
ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30002
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2187

2. FULL NAME William J. Burrow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 9 (Day) 1884 (Year)

7. AGE: 35 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): Sawmill

9. BIRTHPLACE (State or Country): Sprague Wn.

10. NAME OF FATHER: William J. Burrow

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Downs

13. BIRTHPLACE OF MOTHER (State or Country): Kingston N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R.E. Burrow
(Address) Portland Oregon

15. Filed May 8 1920 FLOYD G. WENDLE Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1920 to Feb 17 1920 that I last saw h.mm alive on Feb 17th 1920, and that death occurred on the date stated above, at 1 PM.

The CAUSE OF DEATH* was as follows:
Endocarditis, chronic.

..... (Duration) Unknown yrs. mos. ds.
Contributory (Secondary) Acute rheumatism and Lobar Pneumonia
..... (Duration) ..... yrs. ..... mos. 4 7 ds.

(Signed) A.F. Payne M. D.
19..... (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Idaho — DATE OF BURIAL: 2/21 1920
20. UNDERTAKER: Earl Brower. — ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH
Registration District No. 78
Primary Registration District No. 2135
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30003
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Milan Vincent Campbell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 5 (Day) 1913 (Year)

7. AGE: 6 Yrs. 5 Mos. 7 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hope Ida

10. NAME OF FATHER: James B Campbell

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Mary Natske

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): M B Campbell
(Address): Sandpoint Ida

15. Filed May 8 1920 — Floyd Edwards, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-3 1920 to Feb-7 1920 that I last saw h.im alive on Feb-7 1920 and that death occurred on the date stated above, at 9A M.

The CAUSE OF DEATH* was as follows:
Result of Surgical Operation for Obstruction of bowel.
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Obstruction of Bowel caused by Tumor
(Duration) 3 Yrs. ..... mos. ..... ds.
(Signed) Floyd Edwards, M. D.
2-7 1920 (Address) Sandpoint.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. 4 days. In the City Hospital Sandpoint
State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence Hope Ida

19. PLACE OF BURIAL OR REMOVAL: Hope Ida — DATE OF BURIAL: 2/10 1920

20. UNDERTAKER: Ernest Brower — ADDRESS: Sp

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78

Primary Registration District No. 215 - anderson

File No. 30004

Registered No.

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bruno Louis Albert Van Stephens.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 18 (Day) 1867 (Year)

7. AGE: 57 Yrs. 2 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Belgium

10. NAME OF FATHER: Leonard Van Alsens

11. BIRTHPLACE OF FATHER (State or Country): Belgium

12. MAIDEN NAME OF MOTHER: Stephany

13. BIRTHPLACE OF MOTHER (State or Country): Belgium

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) August Van Stephens

(Address) Sandpoint

15. Filed May 8 192 .

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-2 1920, to 1-5 1920 that I last saw h[e] alive on 1-4 1920 and that death occurred on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal paralysis.
Fecal impaction.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. J. Tidmore M. D.

1/10 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Id — DATE OF BURIAL: 1/12 1920

20. UNDERTAKER: Ellis Brown — ADDRESS: Sp.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2153
File No. 30005
Registered No.

1. PLACE OF DEATH
County Boundary
City of Sandpoint (No. 1038 Cedar St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Hazel Blanche Kaskam
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (write the word)

6. DATE OF BIRTH: Sept. 29, 1899 (Month, Day, Year)

7. AGE: 21 Yrs. 6 Mos. 22 ds.
IF LESS than 1 day: how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Samuel Montague

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Jane Colter

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. F. Kaskam
(Address) Sandpoint, Ida.

15. Filed May 8 1920 — FLOYD G. WENDLE, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 22, 1920 (Month, Day, Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1919, to April 22 1920
that I last saw h.r alive on April 22 1920
and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) Yrs. 4 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. P. Strachan M. D.
4/23 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Sandpoint, Ida.

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. — DATE OF BURIAL: Apr. 24, 1920.
20. UNDERTAKER: B. F. Taylor — ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M.-1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2---
File No. 30006
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Ellen Purvis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 11 (Day) 1860 (Year)

7. AGE: 59 Yrs. 9 Mos. 14 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Israel Robinson

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Rachel Pierce

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Gardner
(Address) Sandpoint

15. Filed May 8 1920 FLOYD G. WENDLE Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920, to March 25 1920, that I last saw h-- alive on March 24 1920, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency and regurgitation

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E J Anderson M. D.

3/7 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: 3/27 1920

20. UNDERTAKER: E M Power — ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Anderson
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2135
File No. 30007
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas J. Hopkins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov 21 1900 (Month) (Day) (Year)

7. AGE: 19 Yrs. 2 Mos. 17 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): Sawmill

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: Thos. Hopkins

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Kitty Deming

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Thos Hopkins
(Address): City

15. Filed May 8 1920
FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 6 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 26 1919, to ~~Nov 21~~ Feb 6 1920, that I last saw him alive on 2-6 1920, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Crushed in mill accident

(Duration) Yrs. mos. 1 day ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. Anderson M. D.
2/7 1920 (Address) Sandpoint Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida
DATE OF BURIAL: 2/9 1920

20. UNDERTAKER: E. M. Brown
ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 213-5
File No. 3008
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME August Aberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH
— (Month) (Day) 1 (Year)

7. AGE: 47 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Jack
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Brown
(Address) SP

15. Filed May 9 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby. 7 1920 to Feby 10 1920
that I last saw h. alive on Feby 10 1920,
and that death occurred on the date stated above, at 1.02 P.M.
The CAUSE OF DEATH* was as follows:
Influenza.

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Taylor M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19.....
20. UNDERTAKER	ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30009

Registration District No. 78
Primary Registration District No. 2153
(No. ..... , ... St.)
Registered No. .....

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Francis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: — (Month) — (Day) 1— (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer Retired
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Brown
(Address) Sandpoint

15. Filed May 8 1920

FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 29 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar-20 1920 to Mar-29 1920
that I last saw him alive on Mar 29 1920
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
.....
.....
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Floyd Wendle M. D.
5/13 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Idaho — DATE OF BURIAL: Apr 1 1920

20. UNDERTAKER: E M Brown — ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2153
File No. 30010
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Donald Moberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: July (Month) 13 (Day) 1917 (Year)
7. AGE: 2 Yrs. 8 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Oscar Moberg
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: Clara Nelson
13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Nelson
(Address) Sandpoint Ida
15. Filed May 8 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1920 to Mar 26 1920, that I last saw him alive on Mar 26 1920, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Dying with

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Floyd G. Wendle M. D.
5-8 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: 3/28 1920
20. UNDERTAKER: E M Brower — ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 30011
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Laclede
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Estella Campbell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 12 (Day) 1875 (Year)

7. AGE: 44 Yrs. 4 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Francis Markham

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Elmina Baker

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. Campbell
(Address) Laclede Ida

15. Filed May 3 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar- 1 1920 to Mar- 7 1920 that I last saw her alive on Mar- 7 1920 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia,

..... (Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Influenza.
..... (Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Floyd Wendle M. D.
3-9 1920 (Address) Sandpoint Ida,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Laclede Ida
DATE OF BURIAL: 3/9 1920

20. UNDERTAKER: E M Brower
ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 8125
File No. 30012
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Alvin Pearson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Febr. (Month) 9 (Day) 1907 (Year)

7. AGE: 13 Yrs. — Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer): N.S.

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: George G. Pearson

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Alice Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Geo G. Pearson
(Address): City Sandpoint

15. Filed May 5 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-16- 1920, to Mar- 3 1920
that I last saw him alive on Mar- 3 1920
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was, as follows:
Pneumonia.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Floyd Gilmore M. D.
5-11 1920 (Address) Sandpoint Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida	5/5 1920
20. UNDERTAKER	ADDRESS
E M Brown	Sandpoint

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2153
File No. 30013
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Parker J. Harrison
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January 17 (Month) (Day) 1871 (Year)

7. AGE: 49 Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Geo Harrison

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mary Dunlap.

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs P. J. Harrison.
(Address): Valley Ida

15. Filed Feb 28 19 20 May 8
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-12-1918 to Feb-19 1920 that I last saw him alive on Feb-19 1920 and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Meningitis
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) La Grippe
(Duration) yrs. mos. — ds.
(Signed) Floyd Wendle M. D.
5-19 1920 (Address) Sandpoint Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 1 days. In the State yrs. mos. days
Where was disease contracted if not at place of death? Valley, Ida,
Former or usual residence Valley, Ida,

19. PLACE OF BURIAL OR REMOVAL: Valley Ida
DATE OF BURIAL: 2/24 19 20

20. UNDERTAKER: Conner
ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30014
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint (If not in incorporated limits, give township) St.)
Registration District No. 78
Primary Registration District No. 2135

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Woods

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: June (Month) 2 (Day) 1893 (Year)

7. AGE: 26 Yrs. ~~8~~ Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Calif Modoc Co.

10. NAME OF FATHER: T. A. Crump.

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Johanna Schadler

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. A. Crump.
(Address) Adel, Oregon

15. Filed May 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb-11 1920 to Feb-11 1920
that I last saw h.r alive on Feb-11 1920
and that death occurred on the date stated above, at 8 a. M.
The CAUSE OF DEATH* was as follows:
Pneumonia,
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. — ds.
(Signed) Floyd Ellenwood M. D.
5-18 1920 (Address) Sandpoint, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
~~Sandpoint Ida~~ Lakeview Oregon	2/22 1920
20. UNDERTAKER	**ADDRESS**
Eve Brower.	Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30015.
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Laclede
(No. , St.)
Registration District No. 78
Primary Registration District No. 2153
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Louder
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Nov (Month) 3 (Day) 1843 (Year)

7. AGE: 76 Yrs. 5 Mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Thos. Mathews

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Elizabeth Nickelbaker

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. C. F. Peacock
(Address) Kootenai Idaho

15.
Filed May 8 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1920, to April 8 1920, that I last saw her alive on April 8 1920, and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows: Mitral Insufficiency

(Duration) Yrs. 9 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Floyd Elliott M. D.
5-13 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Laclede Cem.	4/9 1920
20. UNDERTAKER	ADDRESS
E. M. Brower	Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30016

Registered No.

Registration District No. 78

Primary Registration District No. 2 1 2 1

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

(No. ..... St.) Home

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Loretta Takehara

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Apr (Month) 21 (Day) 1917 (Year)

7. AGE: 7 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Okla.

10. NAME OF FATHER: W. L. Bush

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: May Eglar

13. BIRTHPLACE OF MOTHER (State or Country): Okla

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. Takehara

(Address) Priest River Ida

15. Filed May 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 18 1920, to Jan 19 1920, that I last saw h.. alive on Jan 19 1920, and that death occurred on the date stated above, at 11.45 P.M.

The CAUSE OF DEATH* was as follows:

Acute toxic poisoning following a supposed case of Smallpox

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. J. Pest D.O. ~~M.D.~~

4/8 1920 (Address) Sandpoint Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Priest River Ida.

Former or usual residence Priest River

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida

DATE OF BURIAL: Jan 21 1920

20. UNDERTAKER: Earl Bowser

ADDRESS: S.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30017

Registered No.

1. PLACE OF DEATH

County of Bonner

City of Hope

(No. ..... St.)

Registration District No. 7.8

Primary Registration District No. 2195

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Henry Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 2 (Day) 1841 (Year)

7. AGE: 78 Yrs. 10 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Barre, Mass.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Quebec, Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hattie Stone

(Address) Hope Ida.

15. Filed May 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 19[illegible] to Jan. 19[illegible]

that I last saw h... alive on ... 19[illegible]

and that death occurred on the d... above, at ... M.

The CAUSE OF DEATH* was as f...

[illegible]

(Duration) ... Yrs. ... mos. [illegible] ds.

Contributory (Secondary) [illegible]

(Duration) ... yrs. ... ds.

(Signed) [illegible] M. D.

19... (Address) Hope Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida.

DATE OF BURIAL: May 9 1920

20. UNDERTAKER: [illegible]

ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2133
File No. 30018
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine J. Lawrence
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed.

6. DATE OF BIRTH: Feb (Month) 6 (Day) 18[illegible] (Year)

7. AGE: 77 Yrs. — Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Conn.

10. NAME OF FATHER: J. C. Dennison

11. BIRTHPLACE OF FATHER (State or Country): Conn.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Lawrence
(Address) City.

15. Filed May 8 1920 — FLOYD G. WENDLE, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1919, to Feb. 23 1920, that I last saw h[illegible] alive on Feb 23 1920, and that death occurred on the date stated above, at 5-P M.

The CAUSE OF DEATH* was as follows:
Endocarditis chronic
(Duration) Not Determined yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. A. Boyce M. D.
19 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. — DATE OF BURIAL: 2/26 1920

20. UNDERTAKER: E. M. Brower — ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2177
File No. 30019
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maude Grace Kembree
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 15 (Day) 1897 (Year)

7. AGE: 22 Yrs. 8 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Ed Wallen

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Rose Jacobson

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Kembree
(Address) Sandpoint Ida

15. Filed May 5 1920

FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 29 1920 to Feb 27 1920 that I last saw h[illegible] alive on Feb 27 1920, and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar,

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Small Pox, Influenza + Child birth.
(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) O F Sayler M. D.
19..... (Address) Sandpoint Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida	2/27 1920
20. UNDERTAKER	ADDRESS
E M Bower	Sandpoint.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2 1 8 1
File No. 30022
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Porter Boles Woods. Page

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Febr (Month) 16 (Day) 1846 (Year)

7. AGE: 73 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John S Woods

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Boles.

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. Woods.
(Address) Samuels Idu

15. Filed May 8 1920
FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Oct 10~~ Jan 10 1920, to ~~Nov 24~~ Jan 18 1920, that I last saw h.i.m. alive on ~~Nov 24~~ Jan 18 1920, and that death occurred on the date stated above, at 7:20 A.M.

The CAUSE OF DEATH* was as follows:
~~Bronchial Pneumonia~~
Chronic Endocarditis

(Duration) Not known mos. ~~14~~ ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) O F Gayer M. D.
19 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: 2/ 1920

20. UNDERTAKER: Paul Brown
ADDRESS: SP

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

N. P.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

Primary Registration District No. 2177

File No. 30023

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jas. Gliddwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE 70 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business or establishment in which employed (or employer) Woods

9. BIRTHPLACE (State or Country) Ills

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) -

12. MAIDEN NAME OF MOTHER -

13. BIRTHPLACE OF MOTHER (State or Country) -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Brown
(Address) Sandpoint Ida

15. Filed May 8 1920

FLOYD G. WENDELL
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1920, to March 31 1920, that I last saw him alive on March 31 1920, and that death occurred on the date stated above, at 6:50 P.M.

The CAUSE OF DEATH* was as follows:
Embolism of the brain

..... (Duration) ..... Yrs. ..... mos. 4 ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C F Page M. D.

..... 19..... (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Sandpoint Ida DATE OF BURIAL 4/2 1920

20. UNDERTAKER E. M. Brown ADDRESS Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30024
Registered No.

1. PLACE OF DEATH

County of Bonner

City of Priest River, Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna Bonds

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH

Dec. 1 (Month) 11th (Day) 1888 (Year)

7. AGE

31 Yrs. 4 Mos. 7 Ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Minn.

10. NAME OF FATHER Oscar Skogman

11. BIRTHPLACE OF FATHER (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER Not known.

13. BIRTHPLACE OF MOTHER (State or Country) Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed Bonds

(Address) 117 Division St. Spokane, Wash.

15. Filed May 1 1920

C. P. Getzloff
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 4 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 7 1920, to April 8 1920, that I last saw her alive on April 7 1920, and that death occurred on the date stated above, at 4.30A M.

The CAUSE OF DEATH* was as follows:

Abcess of Lung.

(Duration) -- Yrs 2 1/2 mos. -- ds.

Contributory (Secondary) Spanish Influenza

(Duration) yrs. mos. ds.

(Signed) C. P. Getzloff M. D.

(Address) Priest River, Ida.

April 8 1920

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Priest River

19. PLACE OF BURIAL OR REMOVAL: Wm Davis

DATE OF BURIAL 19

20. UNDERTAKER P. C. C.

ADDRESS Kent

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30025

Registered No.

Registration District No.

Primary Registration District No.

(No. ..... St.)

1. PLACE OF DEATH

County of Bonner

City of Priest River, Ida.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angelo Maio.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Nov. (Month) 25 (Day) 1852 (Year)

7. AGE: 67 Yrs. 4 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy.

10. NAME OF FATHER: Frank Maio.

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Italy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Michael Maio
(Address) Priest River,

15. Filed May 1 1920 — C. P. Gutstaff, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1918, to April 1 1920 19..., that I last saw him alive on March 25 1920 19..., and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease.

(Duration) 5 Yrs. ---- mos. ---- ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Gutstaff M. D.

April 2 1920 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Priest Riv — DATE OF BURIAL: Apr 3 1920

20. UNDERTAKER: Wm Doran — ADDRESS: Newport Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2102
File No. 30026
Registered No. 296

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Freddie Gutierrez
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word.)

6. DATE OF BIRTH: January (Month) 5 (Day) 1920 (Year)

7. AGE: Yrs. 3 Mos. 15 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Albert Gutierrez

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Gutierrez
(Address) Idaho Falls

15. Filed May 20 1920 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h[illegible] alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19..... (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Apr 29 1920

20. UNDERTAKER: Cliff C Hayes — ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 30027
Registered No.

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Clay Lyon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: November (Month) 10 (Day) 1868 (Year)

7. AGE: 57 Yrs. ..... Mos. 5 ds. 0
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Thos. Lyon

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Minerva V. Lyon

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Pearl Lyon
(Address) 150 - 11 - St Idaho Falls Ida

15. Filed Apr. 19 1920 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1920, to April 10 1920, that I last saw h.. alive on April 10 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Encephalitis - Meningitis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Bilateral Otitis Media

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Harry L. Hillaire M. D.

4/15 1920 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Apr. 13 1920

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30028
Registered No. 63

1. **PLACE OF DEATH**

County of Bonneville
City of Idaho Falls
(No. People's Store St.)
Registration District No. 73
Primary Registration District No. 2102

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. B L Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 2. (Day) 1897 (Year)

7. AGE: 23 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Chris Anderson.

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B L Harris
(Address) Idaho Falls Ida

15. Filed Mch 21 - 1920
Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-10- 1920 to 3-17- 1920
that I last saw h. alive on 17th March 1920
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Pneumonia
Termination of Pregnancy
(Duration) ... Yrs. ... mos. 0 ds.
Contributory (Secondary) Influenza -
(Duration) ... yrs. ... mos. 7 ds.
(Signed) H D Hunter M. D.
3/15 1920 (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roberts Ida — DATE OF BURIAL: Mch 21 1920

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

Dr. Hunter

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 30029
Registered No. 62

1. PLACE OF DEATH
County of Bingham
City of Idaho Falls
(No. 5 miles E Idaho Falls St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold George
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single.

6. DATE OF BIRTH: March 25 (Month) (Day) 1900 (Year)

7. AGE: 18 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Jos C George

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Jane Cavanaugh

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe. George
(Address) Idaho Falls Ida.

15. Filed Jan. 14 1920 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 10 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

*Acute Endocarditis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

19..... (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls | DATE OF BURIAL: March 13 1920

20. UNDERTAKER: Clifford Hayes | ADDRESS: Idaho Falls Ida.

Dr. Sims

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 30030
Registered No. 69

1. **PLACE OF DEATH**

County of Bonneville
City of Idaho Falls.
(No. New Sweden, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Chas L Warrant

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: Dec. (Month) 7 (Day) 1903 (Year)

7. **AGE**: 17 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Michigan

10. **NAME OF FATHER**: W C Warrant

11. **BIRTHPLACE OF FATHER** (State or Country): Mich.

12. **MAIDEN NAME OF MOTHER**: Lula Lazell.

13. **BIRTHPLACE OF MOTHER** (State or Country): Mich

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) W C Warrant
(Address) Idaho Falls Ida.

15.
Filed Apr. 13 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Apr. (Month) 9 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Mar. 13 1920, to Apr. 9 1920
that I last saw h.. alive on Apr. 8 1920,
and that death occurred on the date stated above, at P M.
The CAUSE OF DEATH* was as follows:

Ty phoid fever

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Wm Rimmerman M. D.
Apr. 13 1920 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: New Sweden — **DATE OF BURIAL**: Apr. 11 1920.

20. **UNDERTAKER**: Jeff Hayes — **ADDRESS**: Idaho Falls

Wm Rimmerman.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21-0
File No. 30031
Registered No. 60

1. **PLACE OF DEATH**
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Yayoki Kichi Yamoski

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** Japanese

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married
(Write the word.)

6. **DATE OF BIRTH** May (Month) 16 (Day) 1867 (Year)

7. **AGE** 53 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Rancher.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Japan

10. **NAME OF FATHER** ?

11. **BIRTHPLACE OF FATHER** (State or Country) Japan

12. **MAIDEN NAME OF MOTHER** ?

13. **BIRTHPLACE OF MOTHER** (State or Country) Japan.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mr. Kashetaro Mizuki
(Address) Idaho Falls

15. Filed Mch 14 1930 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** March 8th 1930.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 19..... to Dec 8 19.....
that I last saw h..... alive on Dec 8 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
Autopsy Determined

(Duration) Years 1 Mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
Mch 19 30 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Rose Hill Idaho Falls — **DATE OF BURIAL** March 11 1930.

20. **UNDERTAKER** Neff Hayes — **ADDRESS** Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30033

Registered No. 17

1. **PLACE OF DEATH**

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13

Primary Registration District No. 2170

(No. General Hosp St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Sofelia Nordstrom

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** ~~Female~~

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married. (Write the word.)

6. **DATE OF BIRTH** Sept. 1 (Month) 1883. (Day) (Year)

7. **AGE** 37 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Sweden.

10. **NAME OF FATHER** Johnson.

11. **BIRTHPLACE OF FATHER** (State or Country) Sweden.

12. **MAIDEN NAME OF MOTHER** Don't Know.

13. **BIRTHPLACE OF MOTHER** (State or Country) Sweden.

14. **THE ABOVE IS TRUE TO ~~THE~~ BEST OF MY KNOWLEDGE**

(Informant) Carl F Nordstrom

(Address) Mud Lake

15. Filed Feb 19 1920

Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb. (Month) 17 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Feb. 17 1920, to Feb. 17 1920.

that I last saw h[illegible] alive on Feb. 17 1920.

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Septicaemia from retained placenta

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Harry L. Willsey M. D.

2/16 1920 (Address) Idaho Falls Ida –

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Rose Hill | **DATE OF BURIAL** Feb 21 1920.

20. **UNDERTAKER** Hoffman Hagen | **ADDRESS** Idaho Falls

Roy Wilson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30034
Registered No. 17

1. **PLACE OF DEATH**

County of Bonneville

City of Idaho Falls

(No. General Hosp St.)

Registration District No. 73

Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Infant Donnelly.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Single (Write the word.)

6. **DATE OF BIRTH** Feb. (Month) 19 (Day) 1920 (Year)

7. **AGE** Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or 20 min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Idaho Falls Ida.

10. **NAME OF FATHER** L Donnelly.

11. **BIRTHPLACE OF FATHER** (State or Country) Iowa.

12. **MAIDEN NAME OF MOTHER** Sarah Williams

13. **BIRTHPLACE OF MOTHER** (State or Country) Idaho.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) L Donnelly

(Address) Idaho Falls.

15. Filed Sept. 14 1920 W Kinnaird Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb. (Month) 19 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ..... 19..... , to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry L. Wilson M. D.

Feb 19 20 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Rose Hill Idaho Falls | **DATE OF BURIAL** Feb 20 1920

20. **UNDERTAKER** Peffers Hayes | **ADDRESS** Idaho Falls.

Dr Wilson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH,

County of Bonneville

City of Idaho Falls.

Registration District No. 73

Primary Registration District No. 2170

(No. 11 1/2 St & Highway St.)

File No. 30035

Registered No. 135

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo Cromwell.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan 30. 1920
(Month) (Day) (Year)

7. AGE: Yrs. 1 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Falls.

10. NAME OF FATHER Geo Cromwell

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Pearl Peterson

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo Cromwell

(Address) Irwin Ida

15. Filed Apr 14 1920 C. E. Kimmons Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 5 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 5 1920, to Feb. 7 1920

that I last saw h... alive on Feb. 7 1920

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Double Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry L. Wilson M. D.

4/16 1920 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Irwin Cem DATE OF BURIAL: Feb 1920

20. UNDERTAKER: Jeff Kaysing ADDRESS: Idaho Falls

Dr W. L. Wilson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21 v 0
File No. 30036
Registered No. U 8

1. **PLACE OF DEATH**

County of Bonneville
City of Idaho Falls
(No. 130 — 10 St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Louisa Hansen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female
4. **COLOR OR RACE** White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married (Write the word.)

6. **DATE OF BIRTH** Feb. (Month) 19 (Day) 1901 (Year)

7. **AGE** 39 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Siam

10. **NAME OF FATHER** Cap Hit

11. **BIRTHPLACE OF FATHER** (State or Country) England

12. **MAIDEN NAME OF MOTHER** Mek Thong.

13. **BIRTHPLACE OF MOTHER** (State or Country) Siam

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Ludwick Hansen
(Address) Idaho Falls

15. Filed Apr 19 1920 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Feb. (Month) 16. (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Feb 14 1920, to Feb 16 1920
that I last saw her alive on 2-16 1920.
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Influenzal Pneumonia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) S D Shaup M. D.
3-12 1920. (Address) 206 Standrup

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Los Angeles Cal. | **DATE OF BURIAL** Oct 1920

20. **UNDERTAKER** Cliff Hayes | **ADDRESS** Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30037
Registered No. 3-4

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. 19 1st St.)
Registration District No. 73
Primary Registration District No. 2170
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary A Pocteau

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: May (Month) 28 (Day) 1842 (Year)

7. AGE: 78 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Elijah Gates.

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Rachel Weymouth.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Jennie S.
(Address): Idaho Falls Idaho

15. Filed Feb 14 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920 to Feb 7 1920 that I last saw h[illegible] alive on Feb 7th 1920, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema
due to Endocarditis.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. A. Hollister, M. D.
Feb 9 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill | DATE OF BURIAL: Feb. 9 1920

20. UNDERTAKER: Jeff Hayes | ADDRESS: Idaho Falls

Dr. Hollister

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 214-0
File No. 30042
Registered No. 47

1. **PLACE OF DEATH**
County of Bonneville
City of Idaho Falls
(No. Spencer Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Chas Richie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** male
4. **COLOR OR RACE** white
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** married (Write the word.)

6. **DATE OF BIRTH** Oct (Month) 18 (Day) 1863 (Year)

7. **AGE** 57 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Rancher.
(b) General nature of industry, business or establishment in which employed (or employer) ...

9. **BIRTHPLACE** (State or Country) Iowa.

10. **NAME OF FATHER** Richie

11. **BIRTHPLACE OF FATHER** (State or Country) Don't Know.

12. **MAIDEN NAME OF MOTHER** "

13. **BIRTHPLACE OF MOTHER** (State or Country) " "

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs. Chas Richie
(Address) Swan Valley.

15. Filed Apr. 14 1920 C. Townsend Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** March (Month) 29 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from March-1 1919, to March-29 1920
that I last saw h.e alive on March-29 1920
and that death occurred on the date stated above, at 11 A.M.
The **CAUSE OF DEATH*** was as follows:

Tuberculosis of Lungs

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) H. D. Spencer M. D.
March 29 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. **PLACE OF BURIAL, REMOVAL** Rose [redacted] Falls — **DATE OF BURIAL** Apr 1 1920

20. **UNDERTAKER** [redacted] — **ADDRESS** Idaho Falls

Dr. Spencer

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30043
Registered No. 48

Registration District No. 73
Primary Registration District No. 2130

1. **PLACE OF DEATH**
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** William L. McConnell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. **DATE OF BIRTH** Sept. (Month) 2. (Day) 1871 (Year)

7. **AGE** 49 Yrs. 5 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Lawyer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Hickory Penn.

10. **NAME OF FATHER** Wm. Alexander McConnell

11. **BIRTHPLACE OF FATHER** (State or Country) —

12. **MAIDEN NAME OF MOTHER** Agnes McKitrick

13. **BIRTHPLACE OF MOTHER** (State or Country) —

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Helmuth to Mr Connell
(Address) Idaho Falls. Idaho

15. Filed Apr. 20 1920 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Apr. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 3 1920 to Apr. 4 1920
that I last saw h. liv alive on Apr. 1920
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
Apr 7 1920 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rose Hill Idaho Falls	Apr. 7 1920

20. UNDERTAKER	ADDRESS
Clifford Hayes	Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30044
Registered No. .....

Registration District No. 79
Primary Registration District No. 215-6

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Violet Delores Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W.	

6. DATE OF BIRTH. Nov (Month) 23 (Day) 1917 (Year)

7. AGE 2 Yrs. 4 Mos. 3 ds. IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Minn.

10. NAME OF FATHER Geo. H. Wilson

11. BIRTHPLACE OF FATHER (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Agnes Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. H. Wilson
(Address) .....

15. Filed Mar. 28 1930. ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar (Month) 26 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 18 1930 to Mar. 26 1930 that I last saw h.r alive on Mar. 25 1930, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral meningitis
.....
.....
.....(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Influenza
.....(Duration) ..... Yrs. ..... mos. 7 ds.

(Signed) E E Ire M. D.
3/28 1930 (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Eagleband Minn — DATE OF BURIAL ..... 191...

20. UNDERTAKER O'Rourke — ADDRESS Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 315-6
File No. 30015
Registered No.

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claude Milton Wing

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Widower

6. DATE OF BIRTH. May (Month) 15 (Day) 1893 (Year)

7. AGE 26 Yrs. 11 Mos. 1 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) N. P. Ry.

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Alva Clarence Wing

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Florilla Howard

13. BIRTHPLACE OF MOTHER (State or Country) Kans

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. C. Wing
(Address) Rockford Wash

15. Filed Mar. 19th 1920 E E Fry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1920 to April 16 1920
that I last saw h[illegible] alive on April 16 1920
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Compound Comminuted
Fracture of Skull
(Duration) Yrs. mos. 8 ds.
Contributory (Secondary) Acute meningitis
(Duration) Yrs. mos. 6 ds.
(Signed) A. T. Fancett M. D.
Apr. 7 1920 (Address) Bonners Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos. 8 days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Spokane Wash

19. PLACE OF BURIAL OR REMOVAL Spokane Wash — DATE OF BURIAL ..... 191...

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2129
File No. 30047
Registered No.

1. PLACE OF DEATH

County of Butte
City of Moore
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary Ella Lemmon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: ~~Male~~ Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: November (Month) 4 (Day) 1896 (Year)

7. AGE: 24 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Hagerman, Idaho

10. NAME OF FATHER: Soloman E. Parker

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER: Lilly G. White

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Richard S. Lemmon
(Address) Moore, Idaho

15.
Filed 4/5/20 19
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 (Month) 4 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/4 19 20 to 4/4 19 20
that I last saw her alive on 4/4 19 20
and that death occurred on the date stated above, at 12 P.M.
The CAUSE OF DEATH* was as follows:
Septicaemia

(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Childbirth 3/30/20
(Duration) yrs. mos. 6 ds.

(Signed) [signature] M. D.
4/4/ 19 20 (Address) Arco, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moore, Idaho
DATE OF BURIAL: 4/8 19 20

20. UNDERTAKER: W. R. Wells
ADDRESS: Moore, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30948

Registered No. 788

1. PLACE OF DEATH

County of Canyon

City of Caldwell

(No. ..... , ... St.)

Registration District No. 3

Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME D. Benton Graves

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): S

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: about 27 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Barber.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Delbert Graves

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. F. Groves

(Address) Meridian Idaho

15. Filed May 10 1920 John S. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1920, to May 8 1920, that I last saw him alive on May 7 1920, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

..... (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Narcotism (unknown)

Indefinite (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. G. Young M. D.

6/8 1920 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kansas City, Mo.

DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: .....

ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 7005
File No. 30049
Registered No. 67

1. PLACE OF DEATH

County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Holst

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH May 7 1920
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER H. Holst

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Cecile Lyon

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Pete Walther
(Address) Caldwell

15. Filed May 9 1920 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1920 to May 8 1920
that I last saw him alive on May 8 1920,
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows: Premature birth,
prematurity 7 mo.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Jones M. D.
5/8 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	May 9 1920

20. UNDERTAKER CASE FURNITURE CO. ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 30050
Registered No. 68

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beryl Marie Shuee
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word)

6. DATE OF BIRTH: Aug 22 1901 (Month) (Day) (Year)

7. AGE: 18 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: D. N. Shuee

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Amelia E. Hey.

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wesley E. Shuee
(Address) Caldwell, Idaho

15. Filed May 9 1920 John S. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 7 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from March 20 1919 to May 7 1920 that I last saw h.. alive on May 7 1920, and that death occurred on the date stated above, at 9-45 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma Mediastinum
..... (Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Endocarditis
..... (Duration) 4 yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
May 9 1920 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	5-9 1920
20. UNDERTAKER	ADDRESS
E. V. Peckham	Caldwell.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 30051
Registered No. 67

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary A. Riddle
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	m

6. DATE OF BIRTH: Dec (Month) 16 (Day) 1844 (Year)

7. AGE: 75 Yrs. 4 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeping.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: William G Simons

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Caroline Skinner

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. M. C. Bilyeu
(Address) Caldwell, Idaho

15. Filed May 8- 1920 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to May 6 1920, that I last saw h[illegible] alive on May 4 1920, and that death occurred on the date stated above, at 9-30 A.M.

The CAUSE OF DEATH* was as follows:

Hypostatic
Chronic Nephritis

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. W. Coon M. D.

5/8 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 5-8 1920

20. UNDERTAKER: H. Peckham ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2005
File No. 30052
Registered No. 66

1. **PLACE OF DEATH**

County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Stanley Leroy Hollinger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	

6. **DATE OF BIRTH** May (Month) 3 (Day) 1920 (Year)

7. **AGE** ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 5 hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Idaho.

10. **NAME OF FATHER** Homer Hollinger

11. **BIRTHPLACE OF FATHER** (State or Country) Kansas.

12. **MAIDEN NAME OF MOTHER** Ema Jones.

13. **BIRTHPLACE OF MOTHER** (State or Country) Idaho.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Homer Hollinger
(Address) Caldwell, Idaho

15. Filed May 4 1920 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** May (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1920, to May 30 1920 that I last saw h.... alive on May 3 1920 and that death occurred on the date stated above, at 5-30 A.M.

The CAUSE OF DEATH* was as follows:
Pneumatosis - Failure of orificum Heart by Cloud (Blue Baby)
(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M Bailey M.D.
5-4 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	5-4 1920
20. UNDERTAKER	**ADDRESS**
C. A. Peckham	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

File No. 30053

Registered No. 65

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas Newman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
male	white	single

6. DATE OF BIRTH: March 17 (Month) (Day) 1840 (Year)

7. AGE: 80 Yrs. 1 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Thos. Newman

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Johanna Hubard

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walt Davis

(Address) Caldwell, Ida.

15. Filed May 6 1920

John D Reeves
Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:

Fracture of skull

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Runaway

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. G. Young M. D.

..... 19..... (Address) Caldwell Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill.	5-6 1920
20. UNDERTAKER	ADDRESS
Peckham	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Dr. Cole.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

File No. 30054

Registered No. [illegible]

County of Canyon

City of Caldwell - Rural (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H Chambers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Feb 28th (Month) 1865 (Day) 1 (Year)

7. AGE: 5-5- Yrs. Mos. 2 ds. 2

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Nicholas Chambers

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Holt

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret Chambers

(Address) Caldwell Idaho

15. Filed 5-4- 1920 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1920, to May 2 1920 that I last saw h[illegible] alive on May 2 1920, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) ..... Yrs. ..... mos. 17 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

5/3 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: May 4 1920

20. UNDERTAKER: Case Furn + Undertaking — ADDRESS: Caldwell Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30055
Registered No. 62

Registration District No. 9
Primary Registration District No. 1005

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Celia Probst

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	widowed

6. DATE OF BIRTH: Aug (Month) 9 (Day) 1854 (Year)

7. AGE: 65 Yrs. 8 Mos. 20 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER B. Steunenberg

11. BIRTHPLACE OF FATHER (State or Country) Holland

12. MAIDEN NAME OF MOTHER Cornelia Keppel

13. BIRTHPLACE OF MOTHER (State or Country) Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S. Steunenberg
(Address) Caldwell Idaho.

15. Filed 5-1-1920 John L. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1920, to April 30 1920, that I last saw her alive on April 29 1920, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Cardiac insufficiency

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. R. F. Hadsell M.D.
19..... (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	May 2 1920

20. UNDERTAKER	ADDRESS
CASE FURNITURE CO.	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

County of Canyon

Primary Registration District No. 2004

City of Caldwell (No. Caldwell Hospital St.)

File No. 30056

Registered No. 69

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm. Frank Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 5 (Day) 1866 (Year)

7. AGE: 53 Yrs. 9 Mos. 24 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Chas Edwards

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Walford

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Edwards
(Address) Nampa Ida

15.
Filed 4-30- 1920
John S. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 23 1920 to Apr. 28 1920, that I last saw h[illegible] alive on Apr. 28 1920, and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Pernicious Lis following operation for Ruptured Gall Bladder

(Duration) .....Yrs. .....mos. 5 ds.

Contributory (Secondary)

(Duration .....yrs. .....mos. .....ds.

(Signed) G. F. Perrott M.D.

19..... (Address) Caldwell Ida. 10:15 Mo.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 4-30 1920

20. UNDERTAKER: F. K. Robinson — ADDRESS: Nampa

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30057

Registered No. 59

1. PLACE OF DEATH.

County of Canyon

City of Caldwell (No. ....., ... St.)

Registration District No. .....

Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Johnathan F. Allsberry.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 12 (Day) 1863 (Year)

7. AGE: 56 Yrs. 10 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri.

10. NAME OF FATHER John Allsberry.

11. BIRTHPLACE OF FATHER (State or Country) Illinois.

12. MAIDEN NAME OF MOTHER Mary Meadows.

13. BIRTHPLACE OF MOTHER (State or Country) Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jon Allsberry
(Address) Parma #1

15. Filed 4-26-1920 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1920, to April 27 1920, that I last saw h... alive on April 27 19[illegible], and that death occured on the date stated above, at 10-30 A.M.

The CAUSE OF DEATH* was as follows:

Gunshot wound, [illegible] of [illegible]
[illegible] [illegible] [illegible] [illegible]
[illegible] [illegible] [illegible] [illegible] exit.

(Duration) ..... Yrs. ..... mos. 2 hours ds.

Contributory (Secondary) Secondary hemorrhage

(Duration ..... yrs. ..... mos. 1 week ds.

(Signed) [illegible] M. D.

4/27 19[illegible] (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burn Cem. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: E. W. Beckham ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Kelly

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30058

Registered No. 58

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

P. PLACE OF DEATH.

County of Canyon

City of Caldwell

Registration District No. 3

Primary Registration District No. 1005

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Kipp.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug (Month) 15 (Day) 1919 (Year)

7. AGE: Yrs. 8 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER F. S. Kipp.

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Lola Morgan

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Lulu S. Kipp
(Address) Caldwell Idaho

15. Filed 4-19- 1920 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920, to April 17 1920, that I last saw her alive on April 17 1920, and that death occured on the date stated above, at 12 1/4 M.

The CAUSE OF DEATH* was as follows:
Cardiac exhaustion
Following erysipelas Face

(Duration) Yrs. 7 mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. 2 mos. ..... ds.

(Signed) ..... M. D.

1920 (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Caldwell Cem. DATE OF BURIAL: 4/19 1920

20. UNDERTAKER: Peckham ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. ..... St.)

File No. 30059
Registered No. 57

1. PLACE OF DEATH.
County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephen James Vaudrey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 30 (Day) 1834 (Year)

7. AGE: 86 Yrs. 2 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: Stephen Vaudrey

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Stephen J. Vaudrey
(Address) Nampa Ida

15. Filed 4-19-1920
John L. Meyer
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1 1920, to Apr 18 1920, that I last saw h. alive on Apr 16 1920, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Arterio-sclerosis
Chronic Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) I. L. Foster M. D.
4/19 1920 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 4-20-1920

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2005

File No. 30060

Registered No. 56

County of Canyon

City of Middleton (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Parker Knight

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.: January (Month) 19 (Day) 1914 (Year)

7. AGE: 6 Yrs. 2 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: C. M. Knight

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Marie M. Knight

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. M. Knight

(Address) Middleton Idaho

15. Filed 4-18- 1920

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 11 a. M.
The CAUSE OF DEATH* was as follows: Dropsy

..... (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Valvular heart

..... (Duration) ... yrs. ... mos. ... ds.

(Signed) C. M. Knight M. D.

19..... (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton Ida — DATE OF BURIAL: 4-[illegible] 191[illegible]

20. UNDERTAKER: E. J. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNG - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30061

Registered No. 41

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 9

County of Canyon

Primary Registration District No. 4007

City of Caldwell

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa McCreight

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: June (Month) 26 (Day) 1846 (Year)

7. AGE: 73 yrs. 7 mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Jesse Dodds

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Margaret Shannon

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. McCreight
(Address) Parma Ida

15.
Filed March 6 1920 Ruby Waldron Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 31 1920, to March 6 1920, that I last saw her alive on Jan 31 1920, and that death occurred on the date stated above, at 24 M.

The CAUSE OF DEATH* was as follows:
Paralysis following Arteriosclerosis

(Duration) yrs. 2 mos. — ds.

Contributory (Secondary) Debility following fracture of hip

(Duration) 1 yrs. 6 mos. ds.

(Signed) Chas. B. Allen M. D.

March 9 1920 (Address) Parma Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Seaman Ohio — DATE OF BURIAL: ..... 191..

20. UNDERTAKER: Freeborn Care Co — ADDRESS: Parma Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2007
File No. 30062
Registered No. 6

1. PLACE OF DEATH.
County of Canyon
City of Parma
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alwine Schmid

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct (Month) 2 (Day) 1856 (Year)

7. AGE: 63 Yrs. 6 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Wilchen Maurer

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Mathilde Schiderer

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carl Ehrensperger
(Address) Parma

15. Filed Apr 20 1920 Ruby Waldorf Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1920, to Apr. 19 1920, that I last saw h-r alive on Apr. 18 1920, and that death occured on the date stated above, at 1a M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. — mos. 3 ds.

Contributory (Secondary) Hemorrhage

(Duration 2 yrs. — mos. — ds.

(Signed) H. E. Waldorf M. D.

Apr 20 1920 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma
DATE OF BURIAL: Apr 22 1920

20. UNDERTAKER: Perkins Cox
ADDRESS: Parma

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30063

Registered No. 6

1. PLACE OF DEATH.

Registration District No.

Primary Registration District No.

County of Canyon

City of Parma Ida (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Francis Dibbern

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
M	W	S (Write the word.)

6. DATE OF BIRTH: June (Month) 24 (Day) 1906 (Year)

7. AGE: 13 yrs. 7 mos. [redacted] ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER J. L. Miller

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Fannie Dillburg

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Miller

(Address) Parma

15. Filed Apr 12 1920 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 10 1920 to Apr. 10 1920 that I last saw him alive on Apr 1st 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Fracture of skull Fracture of Cavency in Vof Sand.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Mitchell M. D.

4/12 1920 (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Roswell — DATE OF BURIAL Apr 12 1920

20. UNDERTAKER [illegible] Co — ADDRESS Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 1006

(No. State Sanitarium St.)

File No. 30064

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Manual Purdue

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 26 (Day) 1905 (Year)

7. AGE: 14 Yrs. 3 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Colo.

10. NAME OF FATHER: C. H. Purdue

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Clara Carr

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. O. Poynter

(Address) Nampa Idaho

15. Filed May 6 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 24 1920, to April 16 1920, that I last saw him alive on April 16 1920, and that death occured on the date stated above, at 4.15 P.M.

The CAUSE OF DEATH* was as follows:

Acute Articular Rheumatism

(Duration) ~~Mo.~~ Yrs. ..... mos. 14 ds.

Contributory (Secondary) Measles

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. O. Poynter M. D.

1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs 3 mos. 16 days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence St Anthony Idaho

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 4/18 1920

20. UNDERTAKER: J. K. Robinson — ADDRESS: Nampa, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24854

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 30065
Registered No. ____

City of Nampa (No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frederick Brunzell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower
6. DATE OF BIRTH. Sept (Month) 27 (Day) 1833 (Year)
7. AGE: 86 Yrs. 7 Mos. 8 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): (Retired)
9. BIRTHPLACE (State or Country): Sweden
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country): Sweden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. O. Brunzell
(Address) Nampa, Ida.
15. Filed May 6 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15, 1919, to May 5, 1920, that I last saw him alive on May 5, 1920, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage.

(Duration) 0 Yrs. 0 mos. 2 ds.
Contributory (Secondary): Senility
(Duration ____ yrs. ____ mos. ____ ds.

(Signed) Geo. O. L. Kellogg M. D.
19____ (Address) Nampa, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem-Boise | DATE OF BURIAL: 5-7 1920
20. UNDERTAKER: J. K. Robinson | ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTGS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30066

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

2. FULL NAME Infant Hays

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Apr. 26, 1920 (Month) (Day) (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many 0 hrs. or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER R.W. Hays

11. BIRTHPLACE OF FATHER (State or Country) Neb.

12. MAIDEN NAME OF MOTHER Virginia Price

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R.W. Hays

(Address) Nampa Ida.

15. Filed April 30 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr 26 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 24- 1920, to Apr. 26- 1920, that I last saw h[illegible] alive on Apr. 26- 1920, and that death occured on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration — yrs. — mos. — ds.

(Signed) Geo. A. Kelly M. D.

19 (Address) Nampa, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 4-27 1920

20. UNDERTAKER: J.T. Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30067

Registered No. .....

Registration District No. 7

Primary Registration District No. 7006

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carlton Pitkin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 25 (Day) 1866 (Year)

7. AGE 54 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed April 30 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Fell dead in doorway,
presumably from Chronic Heart
Disease, probably heart failure.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Beckham Caldwell Idaho M.D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kohlerdam Cem. DATE OF BURIAL 4/26 1920

20. UNDERTAKER H. K. Robinson ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
(No. Idaho State Sanitarium St.)

File No. 30068
Registered No. .....

1. PLACE OF DEATH.

County of Canyon
City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Brodie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): .....

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15.
Filed April 16 1920 Pearle Dodds
Local Registrar

No further information obtainable
Pearle Dodds
Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1920, to April 14 1920, that I last saw h[illegible] alive on April 14 1920, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Measles
(Duration ..... yrs. ..... mos. 7 ds.

(Signed) D. O'Rourke M. D.
19..... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos 24 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Aberdeen Idaho

19. PLACE OF BURIAL OR REMOVAL: American Falls Ida
DATE OF BURIAL 191

20. UNDERTAKER: Fred K Robinson
ADDRESS: Nampa

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30070

Registered No. .....

Registration District No. 7

Primary Registration District No. 1006

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. 423 - 6th Ave S St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Tracht

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Nov (Month) 11 (Day) 868 (Year)

7. AGE
51 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Oregon

10. NAME OF FATHER: Wm. Marlatt

11. BIRTHPLACE OF FATHER
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. L. Tracht
(Address) Nampa

15.
Filed May 10 1920 Pearle Dodds
Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 29 1920, to Apr 30 1920, that I last saw her alive on Apr 30 1920 and that death occured on the date stated above, at 11 40 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) Yrs. 7 mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Leo W. Chilton M. D.

5/6 1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: N. L. Cemetery — DATE OF BURIAL: May 2 1920

20. UNDERTAKER: F. K. Robinson — ADDRESS: Nampa

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30071
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. 504 5th + 15th No. ave. St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1006

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lou Dedman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write the word.): Married

6. DATE OF BIRTH. Feb (Month) 25 (Day) 1847 (Year)

7. AGE 72 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER Geo Neal

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Drane

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mr Dedman
(Address) Nampa Ida

15. Filed May 10 1920 Pearle Dodds Local Registrar
F K Robinson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 17 1919, to April 24 1920, that I last saw her alive on 4-24 1920, and that death occured on the date stated above, at 2- a.m.

The CAUSE OF DEATH* was as follows:
Atrophic goiter,
Self administered
(Duration) 1½ years mos. ds.
Contributory (Secondary) Arteriosclerosis
(Duration) about yrs. 6 mos. ds.
(Signed) F K Robinson M. D.
5-6 1920 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: K. L. Cemetery — DATE OF BURIAL: 4-25 1920

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30072

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Nampa

(No. Mercy Hospital St.)

Registration District No. 7

Primary Registration District No. 2006

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank L. Loflin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH. Aug (Month) 1 (Day) 87 (Year)

7. AGE: 32 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Jno. Loflin

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Loudner

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E. M. Loflin

(Address) Nampa Ida

15. Filed May 10 1928. Pearle Dodds Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. (Month) 30 (Day) 191 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 13, 1920, to Apr. 30, 1920, that I last saw h. in alive on Apr. 30, 1920, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary abcess of the upper lobe with secondary involvement of lower lobes.

(Duration) 0 Yrs. 0 mos. 20 ds.

Contributory (Secondary) Exhalation of portion of alveolar process during extraction of tooth.

(Duration 0 yrs. 1 mos. 15 ds.

(Signed) Geo. D. A. Kalogeros M. D.

19..... (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: K. L. Cemetery — DATE OF BURIAL: 5-2 191

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)
File No. 30073
Registered No. 419
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marcellus Case

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 21 (Day) 1852 (Year)

7. AGE: 37 Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Case

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Hannah E Fuller

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Case
(Address): Rigby Ida

15. Filed Apr. 12th 1920 Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11 1920 to Apr. 11 1920
that I last saw h. alive on Apr. 11 1920
and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Heart
from
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
4-11 1920 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby Idaho — DATE OF BURIAL: Apl. 13 1920.

20. UNDERTAKER: Rideout — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 30074
Registered No. 420

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. 521-4th Ave West St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary C. Mullikin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct (Month) 4 (Day) 1861 (Year)

7. AGE: 59 Yrs. 7 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Dryden

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Lydia Musgrave

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. H. Mullikin
(Address) Box 57 = Burley Ida.

15. Filed May 10 1920 D. J. Porterman Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Fracture of Skull.
Auto accident

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) L. D. Talloffy = Coroner ~~M. D.~~
5/9/20 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: 5/12/1920

20. UNDERTAKER: L. D. Talloffy. ADDRESS: Burley Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 117
Primary Registration District No. 2194
(No. ....., ... St.)

Patterson's

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30075
Registered No. 421

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia.
City of Burley.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac L. Sevier.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 18. (Day) 1919. (Year)

7. AGE: ....Yrs. 3 Mos. 14 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: John S. Sevier.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Mary Wixom.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. M. Bayley
(Address) Burley Ida.

15. Filed April 1st 1920 Dr. J. C. Patterson Local Registrar

EVANS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 29 1920, to April 1st 1920, that I last saw h.. alive on April 1st 1920, and that death occured on the date stated above, at 10. a. M.

The CAUSE OF DEATH* was as follows:
Capillary Bronchitis

.....(Duration) .....Yrs. .....mos. 4 ds.

Contributory (Secondary)
.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. C. Patterson M. D.
4-1 1920 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: April 2 1920

20. UNDERTAKER: L. B. Bellogg ADDRESS: Burley

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Gooding

City of Declo

Registration District No. 117

Primary Registration District No. 2196

(No. ....., ... St.)

File No. 30076

Registered No. 422

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grant Bentler.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 21 (Day) 1920. (Year)

7. AGE: #.....Yrs. 3 Mos. #.....ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At Home.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burley Ida.

10. NAME OF FATHER Elzie J. Bentler.

11. BIRTHPLACE OF FATHER (State or Country) Richfield Utah

12. MAIDEN NAME OF MOTHER Zina Stevenson

13. BIRTHPLACE OF MOTHER (State or Country) Enterprise Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. A. Stevenson
(Address) Burley Ida.

15. Filed Apr. 23 1920 Dr. J. E. Patterson Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 22. (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5 1920., to April 22- 1920.; that I last saw him alive on april 7- 1920 and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia.

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) Mal Nestrition

.....(Duration .....yrs. .....mos. .....ds.

(Signed) Samuel D. Rose, M. D.

19..... (Address) Declo Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ~~Declo Ida~~ Burley Ida — DATE OF BURIAL: 4/23/1920

20. UNDERTAKER: L. B. Galloway — ADDRESS: Burley Ida

FORM V. S. No. 5-25 M. 1-16-13

Patterson

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 2196

(No. .... St.)

File No. 30078

Registered No. 429

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lester Chase Hayley.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 2 (Day) 1846 (Year)

7. AGE: 74 Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: James Hayley.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Isabella McBride.

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Leonard Allen.

(Address) Burley Ida.

15. Filed Apr 5th 1920 W. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 4th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1920, to Apr. 4 1920, that I last saw him alive on Apr. 1 1920, and that death occured on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Debility (Senile)

..... (Duration) ..... Yrs Annual mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

4-5 1920 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Ida. DATE OF BURIAL: 4/6/20 1920

20. UNDERTAKER: L. B. Galloway. ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30079
Registered No. .....

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Albion

2. FULL NAME Mrs. Conrad Engleking.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 2 (Day) 1847 (Year)

7. AGE: 75 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many ..... hr. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Rotenberg Germany.

10. NAME OF FATHER: Dumire

11. BIRTHPLACE OF FATHER (State or Country): Rotenberg Germany.

12. MAIDEN NAME OF MOTHER: Sophia Sathgy.

13. BIRTHPLACE OF MOTHER (State or Country): Rotenberg Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Conrad Engleking.
(Address) Albion Ida.

15.
Filed ..... 191.....
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1920 to April 7 1920
that I last saw h[illegible] alive on Jan. 25 1920 a.m.
and that death occured on the date stated above, at 8:20 A.M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration .....yrs.....mos.....ds.
(Signed) [illegible] M. D.
April 9 1920 (Address) Pigeon Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Albion Ida. DATE OF BURIAL: 4/13/1920

20. UNDERTAKER: L. B. Gallogly. ADDRESS: Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 90
County of Clearwater Primary Registration District No. 2168
City of Orofino Ida. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 3082
Registered No. 3
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Verge Daniels

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
About 1882
(Month) (Day) (Year)

7. AGE
About 38 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) N. Carolina

10. NAME OF FATHER W. A. Daniels

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Atkeson
(Address) Orofino Ida

15.
Filed May 3 1920 J. H. Wade Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 5 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 23 1917 to April 5 1920 that I last saw h— alive on April 5 1920 and that death occurred on the date stated above, at 12 20 M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

? ? (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
? (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John W. Givens, M. D.
4/6 1920 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 7 yrs. 3 mos. 13 days. In the State ? yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? I do not know
Former or usual residence. admitted from Latah Co.,

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
North Ida Sanitarium	4/6 1920

20. UNDERTAKER	ADDRESS
W. A. Shaw	Orofino

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 90

County of Clearwater Primary Registration District No. 9168

City of Orofino, (No. ....., ... St.)

File No. 30088

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Stevens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: March 1891 (Month) (Day) (Year)

7. AGE: About 29 yrs. ? mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Stevens
(Address) Orofino, Ida.

15. Filed May 2 1920 J. M. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6 1915, to April 13 1920 that I last saw h... alive on April 13 1920 and that death occurred on the date stated above, at 3 a. M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. 7 mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) J. H. Stevens M. D.
4/13 1920 (Address) Orofino Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 4 yrs 5 mos. 7 days. In the State ? yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? I do not Know
Former or usual residence Latah Co.

19. PLACE OF BURIAL OR REMOVAL: Genesee — DATE OF BURIAL: 4/15 1920

20. UNDERTAKER: W. A. Shaw — ADDRESS: Kendrick

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30085

Registered No. 25

1. PLACE OF DEATH

County of Ogeewatta

City of Orofino

(No. ..... St.)

Registration District No. 9C

Primary Registration District No. 3168

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Washington Dillon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: June (Month) 1 (Day) 1852 (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): .....

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Apr 18 1920 J. M. Tarling Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1920, to April 17 1920 that I last saw h.. alive on April 16 1920 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Internal injuries resulting from log rolling on body.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Tarling M. D.

Apr 17 1920 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cleveland Ohio

DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: W. A. Shaw

ADDRESS: Orofino Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 7168
File No. 30086
Registered No. 39

1. PLACE OF DEATH
County of Clearwater
City of Lenore (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Talmanessey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Red
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1833 (Year)

7. AGE: 87 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos. E. Edwards
(Address) .....

15. Filed May 6 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Old Age and General Break down
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. A. Shaw Coroner ~~M. D.~~
4/9 1920 (Address) Orofino

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Big Gorge Cem — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: W. A. Shaw — ADDRESS Orofino

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30087
Registered No.

1. PLACE OF DEATH.
County of Clark
City of Spencer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 125
Primary Registration District No. 2203
(No. ....., ... St.)

2. FULL NAME H Wyatt

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Unknown 1
(Month) (Day) (Year)

7. AGE about 55 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Hagenbarth
(Address) Spencer Idaho

15.
Filed April 20 1920 W E Jones M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH April (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, ~~That I~~ attended deceased from ..... 191..., to ..... 191...,
that ~~I last saw him~~ alive on ..... 191...,
and that death occurred on the date stated above, at about 4:30 M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W E Jones M. D.
4/20 1920 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Spencer Idaho	4-30-1920

20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Camas (No. 9 St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 125
Primary Registration District No. 2203

File No. 30088
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillian Fay Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: April (Month) 26 (Day) 1926 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Camas Idaho

10. NAME OF FATHER: Arthur R Young

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Dora H Lufkin

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Arthur R Young
(Address): Camas Idaho

15. Filed April 29 1926 C E Jones M D Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 29 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1926, to April 29 1926 that I last saw h[illegible] alive on April 26 1926, and that death occurred on the date stated above, at 6.45 P.M.

The CAUSE OF DEATH* was as follows:

Jaundice

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Jones M. D.

4/29 1926 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Camas Idaho — DATE OF BURIAL: 4-30-1926

20. UNDERTAKER: None — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58
Primary Registration District No. 2138
File No. 30089
Registered No.

1. PLACE OF DEATH

County of Camas
City of Fairfield
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Muffley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Oct (Month) 4 (Day) 1916 (Year)

7. AGE: 3 Yrs. 6 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Fred C. Muffley

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Minnie Hopley.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Casper L. Bach

(Address) Fairfield, Idaho

15.

Filed May 10 1920 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 22 1920, to April 23 1920, that I last saw h.. alive on April 23 1920, and that death occurred on the date stated above, at 11 55 P.M.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Weluchek M. D.

May 10 1920 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19 .....
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58d
Primary Registration District No. 2138
File No. 30090
Registered No.

1. PLACE OF DEATH
County of Camas
City of Soldier
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Philip Ballard
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widowed. (Write the word.)

6. DATE OF BIRTH: August (Month) 15 (Day) 1844 (Year)

7. AGE: 75 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Raucher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Philip Ballard.

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: — — —

13. BIRTHPLACE OF MOTHER (State or Country): US.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walford Ballard
(Address) Soldier, Idaho

15. Filed May 6 1920
L Wilencheck
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1920, to April 24d 1920, that I last saw him alive on April 24d 1920, and that death occurred on the date stated above, at 6 00 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(Duration) 3 Yrs. 1 mos. ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 4 ds.

(Signed) L Wilencheck M. D.
May 6 1920 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Soldier, Idaho. DATE OF BURIAL: April 27 1920.

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
(No. .... St.)
File No. 30091
Registered No. .....

1. PLACE OF DEATH.
County of Custer
City of White Knob
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: August 13 1918
(Month) (Day) (Year)
7. AGE: 1 Yrs. 18 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): White Knob
10. NAME OF FATHER: Gabey W. Wright
11. BIRTHPLACE OF FATHER (State or Country): S L City Utah
12. MAIDEN NAME OF MOTHER: Packard Ada
13. BIRTHPLACE OF MOTHER (State or Country): Springville Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gabey W. Wright
(Address) White Knob
15. Filed 5/24 1920 Rose Nourse Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. 24 1920
(Month) (Day) 191 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 1920, to Feb 24 1920, that I last saw h[illegible] alive on Feb 23 1920, and that death occured on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Broncho pneumonia.
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. F. Finch M. D.
19 ..... (Address) Murray Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191
20. UNDERTAKER | ADDRESS

STAR - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Custer — Registration District No. 76

City of Macray — Primary Registration District No. 2153

(No. ....., ... St.)

File No. 30092

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Burnett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. 2 (Month) 24 (Day) 1834 (Year)

7. AGE: 86 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: David R. Burnett

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Alexander Burnett

(Address) Macray Idaho

15. Filed 5/24 1920 — Rose Monroe, Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1919, to 4/14 1920, that I last saw him alive on 4/14 1920, and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

..... (Duration) ..... Yrs. 1 mos. 1 ds.

Contributory (Secondary) Senility

..... (Duration) Several yrs. ..... mos. ..... ds.

(Signed) F. P. Richards M. D.

4/16 1920 (Address) Macray, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20. UNDERTAKER | ADDRESS

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 54

County of Elmore Primary Registration District No. 2020

City of 4 Miles West of Hill City (No. ....., ... St.)

File No. 30093

Registered No. 92

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles W Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male.	white	married

6. DATE OF BIRTH

..... 1868
(Month) (Day) (Year)

7. AGE

51 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Farmer

(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Kendall

(Address) Fairfield, Idaho

15.

Filed May 1st 1920 Rue Walker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

March 11 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28th 1919, to March 11 1920.

that I last saw him alive on March 1 1920.,

and that death occurred on the date stated above, at 2:00 A. M.

The CAUSE OF DEATH* was as follows:

Left Empyema

..... (Duration) ..... yrs. 4 mos. ..... ds.

Contributory (Secondary) Left Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) L Wilencheck M. D.

April 10 1920 (Address) Fairfield, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hill City, Idaho. DATE OF BURIAL: March 13 1920

20. UNDERTAKER ..... ADDRESS .....

Ment of OCCUPATION is very important. See instructions on back of certificate.

YMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Elmore

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 35

County of Owyhee — Primary Registration District No. 2021

City of Glenns Ferry — (No. ____, ____ St.)

File No. ____

Registered No. 30094

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Earnest Weeks

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Oct. (Month) 14th (Day) 1858 (Year)

7. AGE: 62 yrs. 6 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: E. J. Weeks

11. BIRTHPLACE OF FATHER (State or Country): N. Y. State

12. MAIDEN NAME OF MOTHER: Amanda Weeks

13. BIRTHPLACE OF MOTHER (State or Country): N. Y. State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles C. Weeks
(Address) Glenns Ferry Idaho

15. Filed April 27 1920 — J. W. Doris, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1920, to April 27 1920 that I last saw him alive on Jan. 10. 1920, and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Cardiac Dilatation

(Duration) ____ yrs. 5 mos. ____ ds.

Contributory (Secondary) Asthma

(Duration) 8 yrs. ____ mos. ____ ds.

(Signed) J. W. Doris M. D.

April 27 1920 (Address) Glenns Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs ____ mos ____ ds. In the State ____ yrs ____ mos ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL ____ 191

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

YMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30095

Registered No.

1. PLACE OF DEATH.

Registration District No. 36

Primary Registration District No. 2021

County of Elmore

City of Glenn's Ferry (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orville Dale Morrow

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July (Month) 5 (Day) 1918 (Year)

7. AGE: 1 yrs. 8 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Conrad Morrow.

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Agnes Van Laar.

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Morrow

(Address) Glenn's Ferry Idaho

15.

Filed March 15 1926 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 14 (Month) (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1926, to March 14 1926 that I last saw him alive on March 13 1926, and that death occurred on the date stated above, at 4:30 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... yrs. ..... mos. 14 ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. 21 ds.

(Signed) J. W. Davis M. D.

March 14 1926 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenn's Ferry Idaho

DATE OF BURIAL: March 15 1926

20. UNDERTAKER: James Morrow

ADDRESS: Glenn's Ferry Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30096

Registered No.

Registration District No.

Primary Registration District No.

(No. , St.)

1. PLACE OF DEATH

County of Elmore

City of Glenns Ferry

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Fred J. Koontz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: Jan. (Month) 21 (Day) 1875 (Year)

7. AGE: 35 Yrs. 2 Mos. 16 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Stenographer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Mr. George Koontz.

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Mary Schwallers.

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Nellie Fletcher

(Address) Glenns Ferry Ida.

15. Filed April 8 1920

J. V. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 3d (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..., to 19...

that I last saw h... alive on 19...,

and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows: Acute dilatation of heart

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. H. Gray Morrison

4/6 1920 (Address) Glenns Ferry

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hill City, Idaho

DATE OF BURIAL: 4/9 1920

20. UNDERTAKER: W. M. Bradley

ADDRESS: Boise Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30097
Registered No.

1. PLACE OF DEATH
County of Elmore
City of King Hill
If death occurred away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John J. Oliver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: October (Month) 8 (Day) 1854 (Year)

7. AGE: 66 Yrs. 4 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: John Oliver

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Rosenbarger

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant):
(Address): King Hill, Idaho

15. Filed April 8 1920
J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 13th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Suicide by drowning in Snake River
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. H. Coates, Coroner
2/14 1920 (Address) Emmett Ada Co. Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls - Idaho	4-9 1920

20. UNDERTAKER	ADDRESS
W. M. Bradley	Boise Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30098

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Elmore
City of Glenn's Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2021
(No. , St.)

2. FULL NAME Mrs Ellen Gentner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Nov 24 (Month) (Day) 1834 (Year)

7. AGE: 85 yrs. 5 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Muncy Pa.

10. NAME OF FATHER: Joseph Webster

11. BIRTHPLACE OF FATHER (State or Country): Am

12. MAIDEN NAME OF MOTHER: Martha-

13. BIRTHPLACE OF MOTHER (State or Country): Am

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Clark.
(Address) Glenn's Ferry Idaho

15.
Filed April 30 1920 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from the 12th of April 1920, to April 29th 1920 that I last saw her alive on April 29. 1920, and that death occurred on the date stated above, at 6. P M.

The CAUSE OF DEATH* was as follows:
Exhaustion. Senility

(Duration) yrs. mos. 17 ds.

Contributory (Secondary) Fracture of hip

(Duration) yrs. mos. 17 ds.

(Signed) J. W. Davis M. D.
April 30 1920 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McMinnville Oregon — DATE OF BURIAL: April 30 1920

20. UNDERTAKER: Wm McBratney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 30099
Registered No. 34

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Douglas Sharp.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Apr. (Month) 12 (Day) 1920 (Year)

7. AGE: Yrs. 0 Mos. 0 ds. 0
IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): -

9. BIRTHPLACE (State or Country): Preston

10. NAME OF FATHER: Lester I Sharp

11. BIRTHPLACE OF FATHER (State or Country): Franklin Idaho

12. MAIDEN NAME OF MOTHER: Mary A. Bright

13. BIRTHPLACE OF MOTHER (State or Country): Franklin Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lester I Sharp
(Address) Preston Idaho

15. Filed 4/24 1920 Doak Rulon Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 12 1920, to Apr. 12 1920, that I last saw h... alive on Apr. 12 1920, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Premature & not able to endure from unknown reason -
4 hrs (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Doak Rulon M. D.
4/24 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL	DATE OF BURIAL
Preston	4/24 1920

20. UNDERTAKER ..... ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 30101
Registered No. 30

1. PLACE OF DEATH
County of Franklin
City of Preston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elva Maria Taylor
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 1 1903 (Month) (Day) (Year)

7. AGE: 17 Yrs. ..... Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Preston

10. NAME OF FATHER: Hyrum C. Taylor

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Elizabeth A. Bennett

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hyrum C. Taylor
(Address) Preston

15. Filed 4/26 1920 D. A. Ruckle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 10 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1920 to Apr 10 1920 that I last saw her alive on Apr 9 1920 and that death occurred on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. 3 1 ds.
Contributory (Secondary) Previous Typhoid
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Allen P. Ruckle M. D.
4/12 1920 (Address) Preston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Preston

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: 4/13 1920

20. UNDERTAKER: G. A. Lundquist
ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. (See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Franklin

City of Bancan

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2749

(No. ..... , ... St.)

File No. 30102

Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alma Jensen Mason

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH

Sept (Month) 13 (Day) 1919 (Year)

7. AGE

..... Yrs. 7 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Edgar Mason

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Alma Jensen

13. BIRTHPLACE OF MOTHER (State or Country) New Zealand

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edgar Mason

(Address) Bancan Ida

15. Filed 4/26 1920 Dr. A. R. Cutler Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr. (Month) 13 (Day) 1920 (Year)

March 23

17. I HEREBY CERTIFY, That I attended deceased from Mar 23 1920, to Apr 12 1920, that I last saw h... alive on Apr 9 1920 and that death occurred on the date stated above, at 5:50 P.M.

The CAUSE OF DEATH* was as follows:

Marasmus

..... (Duration) Yrs. 4 mos. 15 ds.

Contributory (Secondary) Starvation

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. R. Cutler M. D.

Apr 13 1920 (Address) Preston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bancida	4/14 1920
20. UNDERTAKER	ADDRESS
G. Lundquist	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

30103

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No.
Registered No. 52

1. PLACE OF DEATH.
County of Franklin
City of Preston

Registration District No. 27
Primary Registration District No. 2118
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anton Jeppesen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 25 (Day) 1877 (Year)

7. AGE: 43 yrs. 1 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Christopher Jeppesen

11. BIRTHPLACE OF FATHER (State or Country): Denmark.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Jeppesen
(Address) Preston Idaho

15.
Filed Apr 10 1920 D. A. Rees
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1 1919, to March 31 1920 that I last saw him alive on March 31 1920 and that death occurred on the date stated above, at 8 45 P. M.

The CAUSE OF DEATH* was as follows:

Pyo-nephrosis.

..... (Duration) 1 yrs. ✓ mos. ✓ ds.

Contributory (Secondary) Stone in kidney Clinical diagnosis.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. States M. D.

..... 19..... (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: 4/5 1920

20. UNDERTAKER: G. A. Lundgren
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

30104

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.,
County of Franklin
City of Fairviews

Registration District No. 27
Primary Registration District No. 2119
(No. ....., ... St.)

File No. .....
Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dallas Bodily Hall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: October 18 1919 (Month) (Day) (Year)

7. AGE: ....yrs. 4 mos. 29 ds.
IF LESS than 1 day how many ....hrs. or ....min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Franklin Co Idaho

10. NAME OF FATHER: Thomas John Hall

11. BIRTHPLACE OF FATHER (State or Country): Fairview Idaho

12. MAIDEN NAME OF MOTHER: Harriett M Bodily

13. BIRTHPLACE OF MOTHER (State or Country): Fairview Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W R Hall
(Address) Fairview Idaho

15.
Filed 3/24 1920 D A R Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mar 17 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7 1920, to Mar 17 1920
that I last saw h[illegible] alive on Mar 16 1920
and that death occurred on the date stated above, at 2 55 M.

The CAUSE OF DEATH* was as follows:
Influenza - Pneumonia

..... (Duration) — yrs. — mos. 10 ds.
Contributory —
(Secondary)
..... (Duration) — yrs. — mos. — ds.

(Signed) ..... M. D.
Mar 17 1920 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Fairview — DATE OF BURIAL: Mar 18 1920

20. UNDERTAKER: No undertaker — ADDRESS: Fairview

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

3019

1. PLACE OF DEATH

County of Franklin

City of Franklin

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2/19

(No. ..... St.)

File No. .....

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rasmus Olsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: November (Month) 21 (Day) 1844 (Year)

7. AGE: 75 Yrs. 5 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Nels S. Petersen

(Address) Preston Idaho

15. Filed 5/1 1920 D. A. Rudd Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1920, to April 18 1920 that I last saw h. IM alive on April 18 1920, and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 0 Yrs. 0 mos. 11 ds.

Contributory (Secondary) Arterio sclerosis

(Duration) / yrs. mos. ds.

(Signed) Curtis Rand M. D.

4/27 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mapleton Cemetery

DATE OF BURIAL: 4-28-1920

20. UNDERTAKER: None

ADDRESS: /

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 30166
Registered No. 16

1. PLACE OF DEATH.
County of Blaine.
City of Hailey.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Curtis L. Jackson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married.

6. DATE OF BIRTH: Nov. 2nd. (Month) (Day) 1868. (Year)

7. AGE: 51 yrs. 6 mos. 16. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: A. J. Jackson.

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Jackson.
(Address) Hailey, Idaho

15.
Filed 5-1 1920 R. H. Wright.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April. (Month) 19 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to April 19 1920;
that I last saw h... alive on April 19 1920;
and that death occurred on the date stated above, at 4:15 M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
..... (Duration) ..... yrs. ..... mos. 1 hour ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Hadley M. D.
April 19 20 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey Idaho. DATE OF BURIAL: 4/21 1920.

20. UNDERTAKER: T. B. Harris. ADDRESS: Hailey.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 30107
Registered No. 17

1. PLACE OF DEATH.
County of Blaine
City of Hailey
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mat. Werry.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED QR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 14th (Day) 1908. (Year)

7. AGE: 11 yrs. 5 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Bellevue, Idaho,

10. NAME OF FATHER: Harry Werry.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Lillian Carr.

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Carr.
(Address) Bellevue

15. Filed 5-1 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

Regal

16. DATE OF DEATH: April 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr-10 1920 to Apr-23 1920
that I last saw h[illegible] alive on Apr-23 1920
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows: Valvular Regurgitation

(Duration) yrs. 2 1/2 mos. ds.
Contributory (Secondary): Influenza

(Duration) yrs. mos. ds.

(Signed) Robert N. Wright M. D.
4/25 1920 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue, Idg — DATE OF BURIAL: 4-26 1920

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 3108
Registered No. 178

1. PLACE OF DEATH.
County of Payette.
City of Gannett. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James L. Bowlden.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Aug. (Month) 29. (Day) 1880 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: James Bowlden.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Ophelia Avery.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J.R. Bowlden
(Address) Gannett, Ida.

15. Filed 5-1 1920 R.H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

Plumer.

16. DATE OF DEATH: April (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1920, to April 24 1920 that I last saw him alive on April 23 1920, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Neuralgia.

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) Dust Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.J. Plumer M. D.

19..... (Address) Hadley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gannett, Ida	4-27 1920

20. UNDERTAKER	ADDRESS
R.T. Hare.	Hailey.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30109

Registered No. 19

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Blaine.
City of Hailey.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022

2. FULL NAME Walter W. Hough.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan. 16 (Month) (Day) 1857. (Year)

7. AGE: 63 yrs. 4 mos. 13. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Daniel Hough.

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania.

12. MAIDEN NAME OF MOTHER: Martha Blackstone

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Claremont, Calif.

15.
Filed 5-1 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April. 29. 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13 1920., to April 25 1920
that I last saw him alive on April 29 1920.
and that death occurred on the date stated above, at 10:05 M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) 30 yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Robert H. Wright M. D.
April 30 1920 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Pomona, Calif. DATE OF BURIAL: 191

20. UNDERTAKER: R. Harris ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine.
City of Bellevue.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022

File No. 30110
Registered No. 20
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth A Werry. Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female.	White.	Married.

6. DATE OF BIRTH: Sept. (Month) 11 (Day) 1844 (Year)

7. AGE: 75 yrs. 7 mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Mr. Cobeldick.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillie M. Wright.
(Address) Bellevue, Idaho.

15. Filed May-3 1920 R. H. Wright-
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 30- (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-1 1920 to Apr-30, 1920
that I last saw h[illegible] alive on Apr-30 1920
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Lymphangitis

(Duration) 1 yrs. mos. ds.
Contributory (Secondary) Senility

(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.
5-1 1920 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue | DATE OF BURIAL: May 3 1920

20. UNDERTAKER: [illegible] | ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Blaine,

City of Hailey,

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No. 2022

(No. ....., ... St.)

File No. 30111

Registered No. 14

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo A. Thompson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Dec. 29th 1903,
(Month) (Day) (Year)

7. AGE 16 yrs. 2 mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho,

10. NAME OF FATHER A. Thompson.

11. BIRTHPLACE OF FATHER (State or Country) Kansas.

12. MAIDEN NAME OF MOTHER Eastwood.

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Turner,

(Address) Hailey Idaho,

15. Filed 5-1 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Wright C. March 2nd 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 20 1920 to Feb. 29 1920 that I last saw h[illegible] alive on Feb. 29 1920 and that death occurred on the date stated above, at 1P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) 9 yrs. mos. 9 ds.

Contributory (Secondary) Flu

(Duration) 2 yrs mos. ds.

(Signed) Robert H. Wright M. D.

3/3 1920 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
RD Harris,	Mar-5 1920
20. UNDERTAKER	ADDRESS
Hailey-	Hailey-

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine.
City of Bellevue.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022

File No. 30512
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Clarke.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female.	White	

6. DATE OF BIRTH
March. (Month) 15th (Day) 1920 (Year)

7. AGE
..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ....
(b) General nature of industry business, or dstablishment in which employed (or employer) ....

9. BIRTHPLACE (State or Country) Bellevue, Idaho.

10. NAME OF FATHER O. D. Clarke.

11. BIRTHPLACE OF FATHER (State or Country) Missouri.

12. MAIDEN NAME OF MOTHER Ora Carter.

13. BIRTHPLACE OF MOTHER (State or Country) Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) x Mrs T Bates
(Address) Bellevue,

15.
Filed 5-1 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dutton.
March. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1920, to Mar 19 1920, that I last saw h[illegible] alive on Mar 18 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Convulsions
.....
.....
5
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. 15 ds.

(Signed) H. H. Dutton M. D.
Mar 19 20 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bellevue, Idaho.	3/19 1920

20. UNDERTAKER	ADDRESS
R. D. Harris.	

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30113

Registered No. .....

1. PLACE OF DEATH.

County of Gooding

City of Bliss

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Hobbs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 29 (Day) 1849 (Year)

7. AGE: 70 Yrs. 9 Mos. 20 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laundryman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: William Hobbs

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Narcissa St Johns

13. BIRTHPLACE OF MOTHER (State or Country): Ohio -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Hobbs
(Address) Bliss

15. Filed 3-20- 1920 H. Carp M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1920, to ..... 191....,
that I last saw him alive on Mar 15 1920,
and that death occured on the date stated above, at 11:20 A.M.

The CAUSE OF DEATH* was as follows:
apoplexy -
20 min
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) arterio sclerosis
(Duration 10 yrs mos ds.
(Signed) H. E. Evans M. D.
19..... (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: 3-21- 1920

20. UNDERTAKER: A. E. Thompson — ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30114

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Naoma May Hoodenpyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 7 - 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gooding Ida.

10. NAME OF FATHER: Walter R. Hoodenpyle

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Louise Meyer

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter R. Hoodenpyle

(Address) Gooding Ida.

15.

Filed 3 - 18 - 1920

F. F. Cary M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar. 18 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 7th 1920, to Mar 18 1920, that I last saw her alive on Mar 17 1920, and that death occurred on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Cromwell M. D.

3/18 1920. (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding Cemetary

DATE OF BURIAL: Mar 18 1920

20. UNDERTAKER: A. E. Thomas Store

ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30115

Registered No.

1. PLACE OF DEATH.

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cora May Smith

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married

6. DATE OF BIRTH May (Month) 28 (Day) 1882 (Year)

7. AGE 37 Yrs. 11 Mos. 28 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Colorado

10. NAME OF FATHER — Tiekun

11. BIRTHPLACE OF FATHER (State or Country) Holland

12. MAIDEN NAME OF MOTHER Dont know

13. BIRTHPLACE OF MOTHER (State or Country) Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J M Smith

(Address) King Hill Ida

15. Filed 5-3-1920

F. F. Cary M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 23 1920, to May 1 1920, that I last saw her alive on May 1 1920 and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of pancreas

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J H Cranwell M. D.

5/1 1920 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 7 days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Gooding — DATE OF BURIAL 5-4-1920

20. UNDERTAKER A E Thompson — ADDRESS Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1024
Primary Registration District No. 70 24
(No. ....., ... St.)

File No. 3011C
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME William H Clifford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: June (Month) 5 (Day) 1869 (Year)

7. AGE: 50 yrs. 10 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer -
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Clifford

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rev Johnson
(Address) Wendell Idaho

15. Filed 5-8- 1920 H Hoag Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1920, to May 4 1920 that I last saw h im alive on May 4 1920, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Hemorrhage caused by self inflicted wounds of the throat 5 min
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Shattered
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H E Lagrue M. D.
May 5 1920 (Address) Gooding -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hagerman Idaho
DATE OF BURIAL: 5-10 1920

20. UNDERTAKER: A E Thompson
ADDRESS: Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30117

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gooding

City of Gooding

2. FULL NAME Ynasio Bilbao

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. about year 1899
(Month) (Day) (Year)

7. AGE about 21 yrs of age
Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Sheepherder
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Spain

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Domingo Aspitare

(Address) Gooding

15.

Filed 3-30-1920 F E Card M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Mar. 30 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 27 1920, to Mar. 30 1920, that I last saw h. im alive on Mar 29 1920, and that death occured on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:
Gunshot wound -

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) F E Card M. D.

1920 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Boise Idaho — **DATE OF BURIAL** Mar 31 1920

20. UNDERTAKER A E Trueblood — **ADDRESS** Gooding

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30118

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Camas

City of Fairfield (No. 48, ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry T. Hopley Muffley

If death occurred in a hospital, institution or camp, give full NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. October 4 (Month) (Day) 1916 (Year)

7. AGE: 3 Yrs. 6 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Fairfield, Idaho

10. NAME OF FATHER: Fred C. Muffley

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Minnie Hopley

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Fred C. Muffley

(Address) Fairfield Idaho

15.

Filed 4-24 1920

F. J. Cary M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1920, to April 23 1920, that I last saw him alive on April 23 1920 and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Tarsh M. D.

(Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho

DATE OF BURIAL: 4-25 1920

20. UNDERTAKER: A. C. Thompson

ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 30119
Registered No.

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Franklin Thrush
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: ~~Oct~~ Nov 2 (Month) 1840 (Day) (Year)

7. AGE: 79 Yrs. 7 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming (Retired)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Jacob Thrush

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Thrush
(Address) Dorral Idaho

15. Filed 4 – 12 – 1920 F.T. Carey M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 10th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1920, to April 10th 1920, that I last saw him alive on April 10 1920, and that death occurred on the date stated above, at 4 a M.
The CAUSE OF DEATH* was as follows:
Mitral regurgitation
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Nephritis
(Duration) yrs. 2 mos. ds.
(Signed) J H Cranmer M. D.
4/13 1920 (Address) Gooding Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Crestline Ohio — DATE OF BURIAL 19

20. UNDERTAKER: C E Thompson — ADDRESS Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30121
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Bliss
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Baby Palmer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
F	W	single

6. DATE OF BIRTH: 3 (Month) — 4 (Day) — 1920 (Year)

7. AGE: Yrs. Mos. 3 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. E. Palmer

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Jennette Clark

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W. E. Palmer
(Address): Bliss, Idaho.

15. Filed 3-8-1920 — F. F. Cary M.D., Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 3 (Month) — 8 (Day) — 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-4-1920., to 3-8-1920 that I last saw her alive on 3-6-1920, and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:

Muco-Colitis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. F. Cary M. D.

3-8-1920 (Address) Gooding Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gooding Idaho	3-8-1920
20. UNDERTAKER	ADDRESS
A. E. Thompson	Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30122
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of Saint
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME John A Downey

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH
— (Month) — (Day) 1857 (Year)

7. AGE
63 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Blacksmith
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER No info

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M C Thornhill
(Address)

15.
Filed Nov 1 1920 J H Tenney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 26, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Probable Apoplexy
Supposed

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER M. C. Thornhill | ADDRESS Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Ford

Registration District No. 126

Primary Registration District No. 2204

(No. ..... St.)

File No. 30123

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Goldie May Dupree

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 27 (Day) 1897 (Year)

7. AGE: 23 Yrs. 9 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Henry Faulman.

11. BIRTHPLACE OF FATHER (State or Country) Illinois.

12. MAIDEN NAME OF MOTHER Mary Schutrum.

13. BIRTHPLACE OF MOTHER (State or Country) Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H R Redman

(Address) Ford Idaho

15. Filed 5-1-20 J M Fenney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 24 1920, to April 3 1920, that I last saw h[illegible] alive on April 2 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Influenza.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J M Fenney M. D.

3-3- 1920 (Address) Ford Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mica Peak Spokane Co. Wn. DATE OF BURIAL: 4/5 1920

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24668

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 30124
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene. (No. 601 Hubbard St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Svea Elora Olson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. July (Month) 24 (Day) 1901 (Year)

7. AGE: 19 Yrs. 9 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Andrew E. Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Clara Westerburg

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Andrew E. Olson

15. Filed May 6th 1920 Gus Nelson Local Registrar

SYMS - YORK CO., PTG. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1920, to May 4 1920, that I last saw h[er] alive on May 3 1920 and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus.
(Duration) ? Yrs. ..... mos. ..... ds.
Contributory (Secondary) Tonsilitis tonsy.
(Duration ..... yrs. ..... mos. 3 ds.

(Signed) John Olwood M. D.
May 4 1920 (Address) Coeur d'Alene. Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cem. C D Alene	5-6 1920
20. UNDERTAKER	ADDRESS
C. Cassedy	C D Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30125

Registered No. 48 [illegible]

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Kootenai

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2050

(No. 16 to 1 Bay St.)

2. FULL NAME James Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: [illegible] (Month) 1 (Day) [illegible] (Year)

7. AGE: about 35 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Caretaker.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): [illegible]

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Coroner Elder

(Address) Coeur d'Alene

15. Filed April 22 1920 Gus Nelson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Gun shot wound in head.

Suicide

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] acting Coroner M. D.

19.... (Address) 617 Lakeside Ave

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 3 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Feb 3 1920

20. UNDERTAKER: [illegible] — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 1050

(No. 504 Garden St.)

File No. 30126

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James E. Corbin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 10 (Day) 1841 (Year)

7. AGE: 78 Yrs. 7 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Brubaker

(Address) Spokane, Wn.

15. Filed April 24 1920 Gus Nelson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 21, 1920, to Jan. 28, 1920, that I last saw h[illegible] alive on Jan 27 1920, and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J. C. Boyd M. D.

Jan 29 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 18 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Jan 31 1920

20. UNDERTAKER: [illegible] — ADDRESS: C d'A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 30127
Registered No. 28

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. Hotel Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lutha E Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or the word.)

6. DATE OF BIRTH: Nov (Month) 1 (Day) 1891 (Year)

7. AGE: 27 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Omaha Nebr

10. NAME OF FATHER: R J Dean

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Martha E McGlaughlin

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jas L. Hill
(Address): Coeur d'Alene

15. Filed April 22 1920 Gus Nelson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 30 1920, to Feb. 5 1920, that I last saw h.. alive on Feb. 5 1920, and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary): Influenza & Tuberculosis.

(Duration) ½ yrs. ..... mos. ..... ds.

(Signed) J Thos Allwood M. D.

Feb 7 1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 2 yrs. 6 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: Feb 7 1920

20. UNDERTAKER: R B Mooney
ADDRESS: Coeur d'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 30128
Registered No. 29

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. C d A Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pvt Fred Sandrus
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 6th (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Fred Sandrus

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Gertrude Swan

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Sandrus
(Address) Coeur d'Alene

15. Filed April 22 1920 Gus Nelson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cardiac Dilatation
Broncho Pneumonia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R B Mooney M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fort Cemetery — DATE OF BURIAL: Feb 8 1920

20. UNDERTAKER: R B Mooney — ADDRESS: C d A Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 29

Primary Registration District No. 1050

(No. 309, Coeur D'Alene Ave St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30129

Registered No. 292

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur D'Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glen Miles

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 15 (Day) 1903 (Year)

7. AGE: 16 Yrs. 8 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: R. J. Miles

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Ida Place

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. J. Miles

(Address) Coeur D'Alene Ida

15. Filed Apr. 15 1920 Gus Nelson Local Registrar

SYMS - YORK CO., PTGS. & BDGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/13. 10 PM 1920, to 4/13-14 Midnight 1920, that I last saw him alive on 4/13-14- Midnight 1920, and that death occured on the date stated above, at 5.30 A.M.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Worthington M. D.

4/14 1920 (Address) 624 Sherman ave

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery C. D'Alene — DATE OF BURIAL: 4-15 1920

20. UNDERTAKER: C. Cassedy — ADDRESS: C'Alene.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30130

Registered No. 28

Registration District No. 29

Primary Registration District No. 1050

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. 809 W. Garden St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna May Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. April (Month) 19 (Day) 1920 (Year)

7. AGE ....Yrs....Mos....ds.
IF LESS than 1 day how many 3 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER A. L. Harris

11. BIRTHPLACE OF FATHER (State or Country) Miss

12. MAIDEN NAME OF MOTHER Annetta Adams

13. BIRTHPLACE OF MOTHER (State or Country) Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. L. Harris
(Address) [illegible] St. 809

15. Filed April 20 1920 Gus Nelson Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 19 1920, to Apr 19 1920, that I last saw h....alive on ....191..., and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows: Pneumonia Both

....(Duration) ....Yrs....mos....ds.

Contributory (Secondary) ....

....(Duration ....yrs....mos....ds.

(Signed) C. D. Duncan M. D.

4/20 19 20 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. CDAlene — DATE OF BURIAL: 4-20 1920

20. UNDERTAKER: C. Cassedy — ADDRESS: CDAlene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30131

Registered No. 1 24

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

Registration District No. 29

Primary Registration District No. 1030

(No. 915 Wallace St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emerald Leone Hult

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Strike out words~~

6. DATE OF BIRTH: Feb (Month) 26 (Day) 1905 (Year)

7. AGE: 14 Yrs. 10 Mos. 5 ds.

IF LESS than 1 day: how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A Hult

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Caroline Pearson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Hult

(Address) Soft Boy Ida

15. Filed April 27 1920 Gus Nelson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 29 1919, to Jany 1 1920 that I last saw her alive on Dec 31 1919, and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. 7 ds.

(Signed) C. E. Worthington M. D.

1/3 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State 4 yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Jan 3 1919

20. UNDERTAKER: [illegible] — ADDRESS: C d'A Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 2950
File No. 30132
Registered No. 75

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
If death occurs away from usual residence, give facts called for under special information.

(No. Coeur d'Alene Highway St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nicholis La Frenz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1864 (Year)

7. AGE: 55 Yrs. 2 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Nicholas La Frenz
(Address) Coeur d'alene Idaho

15. Filed April 22 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That ~~I attended deceased from~~ ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 11:45 A.M.
The CAUSE OF DEATH* was as follows:
Fell from cliff, rocks. Died instantly.
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.
(Signed) W K Hoeldtke M. D.
1/23 1920 (Address) Coeur d'Alene Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 5 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Jan 23 1920
20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 30133

1. PLACE OF DEATH
County of Kootenai
City of
(No. 709 Garden ave St.)
Registered No. 679

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sandra Namania Allison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1890 (Year)

7. AGE: 29 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: C D Dutton

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Emma Hicks

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. C. Allison
(Address): Coeur d'Alene

15. Filed Feb. 19 1920 D D Greenwood Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2 1919, to Jan. 7 1920, that I last saw h.. alive on Jan 17 1920 and that death occurred on the date stated above, at 1130 P M.

The CAUSE OF DEATH* was as follows:

Septic pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) Septicemia / Abscess Renal

(Duration) ..... yrs. ..... mos. 25 ds.

(Signed) J D Owens M. D.

Jan 8 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 0 yrs. 6 mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pullman Wn — DATE OF BURIAL: Jan 10 1920

20. UNDERTAKER: R B Mooney — ADDRESS: C d A Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 2051
File No. 30134
Registered No. 709

1. PLACE OF DEATH
County of Kootenai
City of Post Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Belva Nogle
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June 9 1852 (Month) (Day) (Year)

7. AGE: 67 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Luther Ainsworth

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Mrs Smith

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E M Nogle
(Address) Post Falls

15. Filed May 3 1920 D D Drennen, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16 19~~19~~ to April 7 1920 that I last saw h~~e~~r alive on April 7 1920 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
& Duodenum

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F L MacCauley M. D.
4/6 1920 (Address) Post Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 19 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls Ida — DATE OF BURIAL: 4/6 1920

20. UNDERTAKER: A B Mowry — ADDRESS: P F Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 30135
Registered No. 707

1. PLACE OF DEATH
County of Kootenai
City of
(No. Windy Bay Ida St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas M Lester
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 1 (Day) 1874 (Year)

7. AGE: 75 Yrs. 2 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry, business or establishment in which employed (or employer): Fred Jarbert

9. BIRTHPLACE (State or Country): Cal

10. NAME OF FATHER: J C Lester

11. BIRTHPLACE OF FATHER (State or Country): Nebr

12. MAIDEN NAME OF MOTHER: Mary Whiting

13. BIRTHPLACE OF MOTHER (State or Country): Cal

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J C Lester
(Address) Davenport Wash.

15. Filed May 3 1920 D D Dresmer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....
that I last saw h.... alive on ....19....
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
was in a Stone
when Boat Capsized
(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.
(Signed) D. D Dresmer M. D.
3/14 1920 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. 4 mos. ....days
Where was disease contracted if not at place of death? /
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery Cda
DATE OF BURIAL: 3/28 1920
20. UNDERTAKER: [illegible]
ADDRESS: Cda Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25, M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Coeur d'Alene (No. 1602-7th St.) — Primary Registration District No. 1051

File No. 30136

Registered No. 708

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Michael J Doyle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 29 (Day) 1879 (Year)

7. AGE: 40 Yrs. 9 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): not employed

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Miles Doyle

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizabeth Kenny

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice M Doyle

(Address) Olympia Wn

15. Filed May 3 1920 — D D Greenen, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 14 1920, to Mch. 27 1920, that I last saw h. alive on Mch 22 1920 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J C Mayo M. D.

Mch 28 1920 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 5 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Lawn — DATE OF BURIAL: 3/27 1920

20. UNDERTAKER: [illegible] — ADDRESS: C d'A Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1031
File No. 30137
Registered No. 68

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. South Sherman ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie E Green Warner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1843 (Year)

7. AGE: 77 Yrs. 0 Mos. 7 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Robt E Green

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Margaret Wood

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C D Warner
(Address) Coeur d'Alene Ida

15. Filed Feb 19. 1920 L L Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 24th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1919, to Jan 24 1920 that I last saw h..... alive on..... 19....., and that death occurred on the date stated above, at 10:1 A.M.
The CAUSE OF DEATH* was as follows:

Cancer

(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

(Duration) 1 yrs.....mos.....ds.

(Signed) L L Drennan M. D.
Jan 25 1920 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State 41 yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: Jan 26 1920

20. UNDERTAKER: [illegible]
ADDRESS: c d a Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 30138
Registered No. 810

1. PLACE OF DEATH
County of Ada
City of Boise
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes Mary Harris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Wife (Write the word.)

6. DATE OF BIRTH: Apr. (Month) 19 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds. 6 hr
IF LESS than 1 day how many 6 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada Alberta

10. NAME OF FATHER: William E. Harris

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Annetta Ames.

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Harris
(Address) Boise Idaho

15. Filed May 3. 1920
Registrar's Signature: E. D. Duncan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 19 1920 to Apr 19 1920
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Premature Birth
6. days

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. D. Duncan M. D.
4/19 1920 (Address) Corum & Alexander Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: 4/20 1920

20. UNDERTAKER: None
ADDRESS: C. D. A.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30139

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo Hillchelmy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.

Nov (Month) 16 (Day) 1879 (Year)

7. AGE

45 Yrs. 5 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Bar K-Keeper

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Theadore Willchelmy

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Hellen Coddington

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs E. H. Eggerton

(Address) Seattle Wash

15.

Filed 5/1. 1926. Frank Young Local Registrar

BYRNE - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) 29 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 6:30 a M.

The CAUSE OF DEATH* was as follows: accidently shot in head

.....

.....

.....

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) J. M. Fanning Coroner M. D.

5-5- 1926 (Address) Harrison Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Ida — DATE OF BURIAL: May 1 1926

20. UNDERTAKER: C W Peterson — ADDRESS: Rathdrum Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2 15 5-
File No. 30140
Registered No.

1. PLACE OF DEATH
County of Kootenai
City of Athol
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie R. C Loud
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Mar (Month) 15 (Day) 1843 (Year)

7. AGE: 76 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: Annie Walters

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. G. Lusty
(Address) Athol Idaho

15. Filed May 5 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Febr. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-20 1920, to 2-20 1920, that I last saw her alive on 2-20 1920, and that death occurred on the date stated above, at 1 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E G Anderson M. D.

2/21 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sunnyside Cem. DATE OF BURIAL: 2/22/1920

20. UNDERTAKER: E M Bowers ADDRESS: Ath

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 30141
Registered No. 96

1. PLACE OF DEATH
County of Latah
City of Viola (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera Devota Platz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: March (Month) 28 (Day) 1920 (Year)

7. AGE: ..... Yrs. 1 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Oliver Platz

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Agnes Gutches

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oliver Platz
(Address) Viola Idaho

15. Filed 4/27 1920 N. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1920, to April 27 1920, that I last saw h..... alive on April 27 1920, and that death occurred on the date stated above, at 6 45 M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
.....
.....
..... (Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Clarke M. D.
4/27 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Viola — DATE OF BURIAL: 4/28 1920

20. UNDERTAKER: Allen Price — ADDRESS: Moscow

FORM V. S. No. 5-25 [illegible]-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 30142
Registered No. 98

1. PLACE OF DEATH
County of Latah
City of Moscow.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Morrill
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Widowed

6. DATE OF BIRTH: Nov (Month) 11 (Day) 1844 (Year)

7. AGE: 75 Yrs. 5 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): With Children

9. BIRTHPLACE (State or Country): New York,

10. NAME OF FATHER: James Martin

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Alvira Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs B. C. Hawe
(Address) Moscow

15. Filed 4/29 1920 N. H. Saunders Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 a.m. 1920, to April 28 p.m. 1920, that I last saw her alive on April 28th 1920, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Valvular disease of the heart, Mitral, with post-compensation.
(Duration) 10 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cystitis
(Duration) One yrs. ..... mos. ..... ds.
(Signed) J. W. Hartman M. D.
4/29 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. | DATE OF BURIAL: 4/30 1920
20. UNDERTAKER: Klein Price | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 30143
Registered No. 95

1. PLACE OF DEATH
County of Latah
City of [illegible]
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Morris Manson McGarvey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 20 (Day) 1849 (Year)

7. AGE: 70 Yrs. 4 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Adam McGarvey.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Margret Paterson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John E. McGarvey
(Address): Stavery, Washington

15. Filed 4/25 1920
N. H. Lairthers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 25th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16, 1920 to April 25, 1920 that I last saw him alive on April 25, 1920 and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Curtis M. D.
4/25 1920 (Address) Moscow Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 4/27 1920

20. UNDERTAKER: [illegible]
ADDRESS: [illegible]

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 30144
Registered No. 94

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glen Arthur Morton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1920 (Year)

7. AGE: ..... Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Glen Arthur Morton

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Nettie May Schumacher

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Glen A. Morton
(Address): Moscow

15. Filed 4/20 1920 — D. H. Carothers, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15 1920, to April 20 1920, that I last saw ... alive on April 20 1920, and that death occurred on the date stated above, at 12:30 A.M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
4/20 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 4/20 1920

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 30145
Registered No. 97

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1847 (Year)

7. AGE: 72 Yrs. 4 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Christ Olson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not Known here

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs John Olson
(Address): Moscow

15. Filed 4/24 1920 W. A. Saunders Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 10 1920 to April 13 1920, that I last saw him alive on April 13 1920, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Cowan M. D.
4/24 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow DATE OF BURIAL: May 1 1920

20. UNDERTAKER: Allen Hill ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30146

Registered No. 9

Registration District No. 2

Primary Registration District No. 214

1. PLACE OF DEATH
County of Latah
City of Genesee (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. P. Sievers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Widowed

6. DATE OF BIRTH
Apr (Month) 24 (Day) 185[illegible] (Year)

7. AGE
35 Yrs. 0 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Dentist
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER J. P. Sievers

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pauline Stelz
(Address) Genesee Idaho

15.
Filed Apr. 30 1920 W. N. Ehrman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-27 1920 to 4-27 1920 that I last saw h[illegible] alive on 4-27 1920, and that death occurred on the date stated above, at 9 A M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 4 Yrs. mos. ds.
Contributory (Secondary) Not known
(Duration) yrs. mos. ds.
(Signed) John N Adler M. D.
5-4 1920 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Genesee Idaho	May 4 1920
20. UNDERTAKER	ADDRESS
F. E. Lambert	Kendrick Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ....., ... St.)

File No. 30148
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eliza Ellen Sly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Widowed

6. DATE OF BIRTH
May (Month) 1 (Day) 1837 (Year)

7. AGE
82 yrs. 11 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Kentuckey

10. NAME OF FATHER Joseph Cook

11. BIRTHPLACE OF FATHER (State or Country) Kentuckey

12. MAIDEN NAME OF MOTHER Permelia Cook

13. BIRTHPLACE OF MOTHER (State or Country) Kentuckey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H M Chaney
(Address) Troy

15.
Filed apr 9 1920 J E Pickard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1918, to April 8 1920 that I last saw h[illegible], alive on Apr 8 1920 and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) — yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) — yrs. — mos. — ds.

(Signed) C K Heinkle M. D.

1920 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bethel	apr 11 1920

20. UNDERTAKER	ADDRESS
J E Pickard	Troy

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30149

Registered No.

1. PLACE OF DEATH

County of

City of

(No. , St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Harrison Shenkart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: June (Month) 4 (Day) 1840 (Year)

7. AGE: 79 Yrs. 10 Mos. 9 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tom Walker

(Address) Troy Idaho

15. Filed Apr 10 1920 J E Pickerd Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5 1920, to April 7 1920, that I last saw h alive on April 7 1920, and that death occurred on the date stated above, at 11.20 P M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 5 Yrs. - mos. - ds.

Contributory (Secondary) apoplexy

(Duration) - yrs. - mos. 7 ds.

(Signed) J Mccall M. D.

Apr 1 1920 (Address) Troy Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Apr 1920

20. UNDERTAKER: J E Pickerd — ADDRESS: Troy

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 66
Primary Registration District No. 2146
File No. 8
Registered No. 30150

1. PLACE OF DEATH.
County of Bovill
City of Kalah
(No. Bovill Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Gunlon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 15 (Day) 1864 (Year)

7. AGE: 55 Yrs. 9 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Section Foreman
(b) General nature of industry, business, or establishment in which employed (or employer)... Railroad Employee

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Gunlon (Son)
(Address) Harvard Idaho

15.
Filed 4/9 1920 Mrs T C Gibson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 7th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 29 1920, to April 7th 1920, that I last saw him alive on April 1920, and that death occured on the date stated above, at 6.20 M.

The CAUSE OF DEATH* was as follows:

Transverse Myelitis

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. C. Gibson M. D.

4/7 1920 (Address) Bovill, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 9 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Harvard Idaho

19. PLACE OF BURIAL OR REMOVAL [redacted] Idaho — DATE OF BURIAL ..... 191...

20. UNDERTAKER [redacted] — ADDRESS Palouse Wn

SYMS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30151

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147
Primary Registration District No. 67
File No. 5
Registered No. 30

1. PLACE OF DEATH
County of Latah
City of Deary
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John L. Griffin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: July (Month) 5 (Day) 1866 (Year)

7. AGE: 53 Yrs. 9 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Pelega A. Griffin

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Samantha Mann

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. O. Faust
(Address) Deary

15. Filed 4-27 1920 P. O. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-26 1920 to 4-26 1920 that I last saw h.. in life alive on 4-26 1920 and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Asphyxia (Instantaneous)
(Duration) 0 Yrs. 0 mos. ..... ds.
Contributory (Secondary) Epilepsy
(Duration) 53 yrs. 8 mos. ..... ds.

(Signed) P. O. Faust M. D.
4/27 1920 (Address) Deary

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pine Crest	4-28 1920
20. UNDERTAKER	ADDRESS
J. E. Packard	Troy

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

30152

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Avon P.O.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2147
Primary Registration District No. 67
(No. ....., ..., St.)

File No. 55
Registered No. 28
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest M. King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	W	single

6. DATE OF BIRTH
Sept. 13 1919
(Month) (Day) (Year)

7. AGE
0 yrs. 6 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Wash

10. NAME OF FATHER Hubert King

11. BIRTHPLACE OF FATHER
(State or Country) Wash

12. MAIDEN NAME OF MOTHER Mary Turner

13. BIRTHPLACE OF MOTHER
(State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. C. Faust
(Address) Deary

15.
Filed 4-9 1920 P. C. Faust
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Apr. 5 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...
and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Gastro intestinal trouble
Reported once by phone
by Dr. Hubele

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pine Crest Cem.	4-11 1920

20. UNDERTAKER	ADDRESS
"	"

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30153

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2147

Primary Registration District No. 67

File No. 2

Registered No. 29

1. PLACE OF DEATH

County of Latah

City of Deary

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Katherine Jonn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: Aug. 30 1837
(Month) August (Day) 30 (Year)

7. AGE: 82 yrs. 7 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: Jack Mennie

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Louise Mennie

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. S. Perry
(Address) Deary Idaho

15. Filed 4-14 1920 P. B. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr. 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-1 1920 to 3-31 1920
that I last saw h alive on 3-31 1920
and that death occurred on the date stated above, at 7:00 M.

The CAUSE OF DEATH* was as follows:
Chronic Rheumatic Pericarditis

(Duration) 2 0 yrs. " " mos. " " ds.

Contributory (Secondary) old age

(Duration) 6 " yrs. " " mos. " " ds.

(Signed) P. B. Jones M. D.

4/14 1920 (Address) P. O. Deary

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pine Crest Cem. DATE OF BURIAL: 4-14 1920

20. UNDERTAKER: " ADDRESS: "

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

30154

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Troy P.O.

Registration District No. 2147
Primary Registration District No. 67
(No. ....., ... St.)

File No. 3
Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Lathrop

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Mar. 13 (Month) (Day) 1871 (Year)

7. AGE: 49 yrs. 1 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Iver Andreasson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Signe Nees

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Knud Lathrop
(Address) Troy Idaho

15. Filed 4-25 1920 W. V. Jarrett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1920 to April 19 1920 that I last saw h[er] alive on April 19 1920 and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Insufficiency

..... (Duration) ..... yrs. 2 mos. 5 ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wilson M. D.
April 24 1920 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence 4-26-20

19. PLACE OF BURIAL OR REMOVAL: Zion Cemetery
DATE OF BURIAL: Apr. 26 1920

20. UNDERTAKER: J. E. Pickerd
ADDRESS: Troy.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 68
Primary Registration District No.
(No. , St.)

File No. 30155
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Alexander Adair Pemberton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 14 (Day) 1899 (Year)

7. AGE: 20 yrs. 3 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) Student

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER William D. Pemberton

11. BIRTHPLACE OF FATHER (State or Country) West Virginia

12. MAIDEN NAME OF MOTHER Susan L. Sukens

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susan L. Pemberton
(Address) Kendrick Idaho.

15. Filed 4-7 1920 R. T. Pepple Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 31st 1920, to April 1st 1920, that I last saw him alive on April 1st 1920, and that death occurred on the date stated above, at 2.15 P M.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Infantile Paralysis
(Duration) 9 yrs. ..... mos. ..... ds.

(Signed) W. A. Rothwell M. D.
Apr. 2 1920 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kendrick Idaho
DATE OF BURIAL: Apr. 3rd 1920

20. UNDERTAKER: Elmer Beahtol
ADDRESS: Kendrick Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

Juliaetta Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ney Perces
City of Deland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 68
Primary Registration District No.
(No. ____ St.)

File No. 30156
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Arthur Edwin Hartinger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April 21st 1920 (Month) (Day) (Year)

7. AGE: ____ yrs. ____ mos. 9 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wesley F. Hartinger

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Annie Larson

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wesley Hartinger
(Address)

15. Filed 4-30 1920 R. F. Pepple Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20th 1920, to Ap. 30th 1920, that I last saw him alive on Ap 30th 1920, and that death occurred on the date stated above, at 9.30 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ____ yrs. ____ mos. 3 ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. A. Rothwell M. D.
Ap. 30th 1920 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lawson Cemetery Idaho
DATE OF BURIAL: May 1st 1920

20. UNDERTAKER: none
ADDRESS: —

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Juliette Ide

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

Registration District No. 41
Primary Registration District No. 2116
File No. 30157

County of Lemhi
City of May (No. ..... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** James Montgomery Arter jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male
4. **COLOR OR RACE**: White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED**: Single (Write the word.)

6. **DATE OF BIRTH**: April (Month) 14 (Day) 1918 (Year)

7. **AGE**: 1 Yrs. 22 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business or establishment in which employed (or employer): at home

9. **BIRTHPLACE** (State or Country): [redacted] Idaho

10. **NAME OF FATHER**: James Montgomery Arter Sr.

11. **BIRTHPLACE OF FATHER** (State or Country): Pennsylvania

12. **MAIDEN NAME OF MOTHER**: Myrtle Mary Widdiss

13. **BIRTHPLACE OF MOTHER** (State or Country): Oklahoma

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Myrtle M Arter
(Address) May Idaho

15. Filed 5/10 1920 M. Fleming Green
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: March (Month) 3 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Mar-1- 1920, to Mar 3 1920 that I last saw h[redacted] alive on Mar 3 1920, and that death occurred on the date stated above, at 10 a. M.
The CAUSE OF DEATH* was as follows:

Epidemic Influenza

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O J Gilman M. D.
19 ..... (Address) May Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: May — **DATE OF BURIAL**: 3/5 1920

20. **UNDERTAKER**: None — **ADDRESS**:

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 30158
Registered No.

1. PLACE OF DEATH
County of Lemhi
City of Salmon
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Clower Savage
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	Married

6. DATE OF BIRTH
October (Month) 21 (Day) 1846 (Year)

7. AGE
73 Yrs. 5 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) England

10. NAME OF FATHER George H. Smith

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER Sarral Smith

13. BIRTHPLACE OF MOTHER
(State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John C. Clower
(Address) 1820 Lincoln St Salt Lake City

15.
Filed 5/10 1920
M. Deming Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920 to April 13th 1920 that I last saw her alive on April 13th 1920, and that death occurred on the date stated above, at 4:25 P.M.
The CAUSE OF DEATH* was as follows:
Old age
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. A. Wright M. D.
4/14 1920 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake City Utah	19.....
20. UNDERTAKER	**ADDRESS**
W.W.C. Doebler	Salmon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2416
File No. 30159
Registered No.

1. PLACE OF DEATH
County of Lemhi
City of [redacted]mon
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loren Blanchard Stottler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write this word.): Single

6. DATE OF BIRTH: April (Month) 18 (Day) 1902 (Year)

7. AGE: 63 Yrs. June Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cass County Neb

10. NAME OF FATHER: William Stottler

11. BIRTHPLACE OF FATHER (State or Country): Highland Ohio

12. MAIDEN NAME OF MOTHER: Lucinda Snyder

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Ella Wyant
(Address): Salmon Ida.

15. Filed May 10 1920 M. Doring [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 18th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1920 to April 18 1920.
that I last saw him alive on April 17th 1920
and that death occurred on the date stated above, at 4 A M.
The CAUSE OF DEATH* was as follows:

Uremia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. P. Stratton M. D.
4/18 1920. (Address) Salmon, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Idaho
DATE OF BURIAL: 4-19th 1920

20. UNDERTAKER: Mrs C Doebler
ADDRESS: Salmon Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30160
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Palouse
(No. ....., ... St.)
Registration District No. 41
Primary Registration District No. 2116
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Brooks.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Not known (Month) 1 (Day) (Year)

7. AGE 73 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER " " (State or Country)

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER " " (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alexander Pattison
(Address) Palouse Idaho

15. Filed 5/10 1920 M. Deing Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 14" 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13 1920, to April 13 1920, that I last saw him alive on April 13, 1920 and that death occured on the date stated above, at 6.00 A M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

4/14/20 (Signed) C. B. Bratton M. D.
1920 (Address) Palouse Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Johnson Cemetery — DATE OF BURIAL: 4-16" 1920

20. UNDERTAKER: W. C. Doebler — ADDRESS: Palouse, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lemhi

City of Wynne

Registration District No. 41

Primary Registration District No. 216

(No. ....., ... St.)

File No. 30161

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarence Everet Buster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 7 (Day) 1901 (Year)

7. AGE: 18 Yrs. 7 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: .....

(b) General nature of industry, business, or establishment in which employed (or employer): Laborer - Day

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: John W. Buster

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Nancy E. Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. H. Buchanan

(Address) Wynne

15. Filed 5/10 1920 M. Deming Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 8th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 6 1920, to Feb 8 1920, that I last saw him alive on Feb 8 1920, and that death occured on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows:

Pneumonia- following influenza

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Hammer M. D.

2/10 1920 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 2-9" 1920

20. UNDERTAKER: Wm C Taebler — ADDRESS: Salmon, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 30162
Registered No. .....

1. PLACE OF DEATH.
County of Lemhi
City of Ulysses

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilda Alvetta Leabo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 12 1887
(Month) (Day) (Year)

7. AGE: 32 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER D. L. Wright

11. BIRTHPLACE OF FATHER (State or Country) Georgia

12. MAIDEN NAME OF MOTHER Anna Duzette

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Buchanan
(Address) Ulysses

15. Filed 5/10 1920 M. Vering Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 8th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 8 1920, to Feb 8 1920, that I last saw her alive on Feb 8 1920 and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Influenza & Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Confinement
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Hammel M. D.
(Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 2-9" 1920

20. UNDERTAKER: Wm C Doeller — ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 2116
File No. 30163
Registered No.

1. PLACE OF DEATH
County of Lemhi
City of Salmon
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Young Kee
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Yellow
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: Not known (Month) (Day) 1 (Year)
7. AGE: about 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): China
10. NAME OF FATHER: Not known
11. BIRTHPLACE OF FATHER (State or Country): China
12. MAIDEN NAME OF MOTHER: Not known
13. BIRTHPLACE OF MOTHER (State or Country): China
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Taebbe
(Address) Salmon Ida
15. Filed 5/10 1920 M. Verna Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 19th (Month) (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidently Suffocated due from burning building.
(Duration) 0 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. C. Taebbe Coroner ~~M. D.~~
3-19" 1920 (Address) Salmon Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 3-20" 1920
20. UNDERTAKER: W. C. Taebbe
ADDRESS: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30165

Registered No. .....

1. PLACE OF DEATH.

County of Lemhi

City of North Fork

Registration District No. 41

Primary Registration District No. 2116

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Robert Hull

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): School boy

6. DATE OF BIRTH. July 19th (Month) — (Day) 1906 (Year)

7. AGE: 13 Yrs. 5 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): ~~Lemhi Co~~ Idaho

10. NAME OF FATHER: Chas M Hull

11. BIRTHPLACE OF FATHER (State or Country): Cornwallis Montana

12. MAIDEN NAME OF MOTHER: Olive Flood

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Charles R Hull

(Address) North Fork, Idaho

15. Filed 5/10 1920 M. Dering Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January 16" (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Accidently Crushed to death, due to falling roof

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm C. Hoebler M. D.

1-17 1920 (Address) Salmon Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gibbonsville Cemetery

DATE OF BURIAL: 1-19" 1920

20. UNDERTAKER: Edward Copersmith

ADDRESS: Gibbonsville Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BKBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2428
File No. 30166
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Kamiah
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carrie Powers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. January (Month) 6 (Day) 1915 (Year)

7. AGE: 5 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lewis Co. Ida

10. NAME OF FATHER Frank Powers

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Agnes —

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carrie Powers
(Address) Kamiah Ida

15. Filed 4/10/20 191.....
C J Johnson
Local Registrar

BYRUS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191.....,
that I last saw h..... alive on ..... 191.....,
and that death occured on the date stated above, at 10 A M.
The CAUSE OF DEATH* was as follows:
No Physician in attendance
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind. Cem. No 1 Kamiah
DATE OF BURIAL: 4/12 1920

20. UNDERTAKER C J Johnson
ADDRESS Kamiah Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2428
File No. 30167
Registered No. .....

1. PLACE OF DEATH.
County of Shoshone
City of Idaho Kamiah (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edna I Terry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 7 (Day) 1854 (Year)

7. AGE 69 Yrs. 5 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Georgia

10. NAME OF FATHER Richard Pyle

11. BIRTHPLACE OF FATHER (State or Country) Georgia

12. MAIDEN NAME OF MOTHER Frances Westbrook

13. BIRTHPLACE OF MOTHER (State or Country) Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. M. Terry
(Address) Kamiah Ida.

15. Filed 4/12 1920 C. J. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1917, to April 1920, that I last saw her alive on April 9 1920, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Intestinal Nephritis

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Grayson M. D.
4/12 1920 (Address) Kamiah, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cem. Kamiah Ida — DATE OF BURIAL: 4/12 1920

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 49

Primary Registration District No. 2428

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30168

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis

City of Kamiah

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Michael Matthews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jany (Month) 25 (Day) 1920 (Year)

7. AGE ..... Yrs. 2 Mos. 1 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lewis Co Ida

10. NAME OF FATHER Simon Matthews

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Edna Newman

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon Matthews

(Address) Kamiah

15. Filed 4/12 1920

E J Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1920, to about 191..., that I last saw him alive on April 11 1920, and that death occured on the date stated above, at 12 M.

The ~~CAUSE~~ OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C H Guyer M. D.

4/12 1920, (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ind Cem No 1 Kamiah Ida

DATE OF BURIAL 4/13 1920

20. UNDERTAKER C J Johnson

ADDRESS Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2428
File No. 30169
Registered No. .....

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Addie Wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. September 7 (Month) (Day) 1875 (Year)
7. AGE: 44 Yrs. ..... Mos. 7 ds. 10
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Washington
10. NAME OF FATHER: Archibald McClintic
11. BIRTHPLACE OF FATHER (State or Country): Missouri
12. MAIDEN NAME OF MOTHER: Mary E. McClure
13. BIRTHPLACE OF MOTHER (State or Country): Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. A. D. Martin
(Address) Lewiston Idaho
15. Filed 4/18 1920
J. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1919, to April 1920, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 4-35 P.M.

The CAUSE OF DEATH* was as follows:
Carcinoma breast,
.....
.....
.....(Duration) 1 1/2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas Bryson M. D.
4/19 1920 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Post Cem. Kamiah Ida — DATE OF BURIAL: 4/19 1920

20. UNDERTAKER: W. J. Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 49

Primary Registration District No. 2428

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30170

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis

City of Kamiah

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Matthews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. January 25 (Month) (Day) 1920 (Year)

7. AGE: ..... Yrs. 2 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Lewis Co Ida

10. NAME OF FATHER Simon Matthews.

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Edna Newman

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Simon Matthews

(Address) .....

15. Filed 4/2 1920

C. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April 2 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1920, to ..... 191..., that I last saw him alive on April 2nd 1920, and that death occured on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Acute indigestion

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Bryan M. D.

April 2 1920 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind. Cem. No 1, Kamiah Ida — DATE OF BURIAL: 4/3 1920

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30171

Registration District No. 47

Primary Registration District No. 2128

Registered No. .....

1. PLACE OF DEATH.

County of Kootenai

City of .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abraham James Corbett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 16 (Day) 1919 (Year)

7. AGE: ..... Yrs. 8 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Co. Idaho

10. NAME OF FATHER: Paul Corbett

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lydia Smith

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Paul F. Corbett

(Address) Kamiah Ida

15. Filed 4/17 1920

C. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16th 1920, to alive 191..., that I last saw h= alive on alive 191..., and that death occured on the date stated above, at 9.40 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

.....(Duration) .....Yrs. .....mos. 4 ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) C. J. Johnson M. D.

4/17 1920 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pres. Cem. No. 1. Kamiah Ida — DATE OF BURIAL: 4/19 1920

20. UNDERTAKER: C. J. Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PYRS. & SORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1076

Primary Registration District No. 1076

File No. 30172

Registered No. 13

1. PLACE OF DEATH.

County of Lincoln

City of Laidlow Park

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo R Herman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): unknown

6. DATE OF BIRTH. Nov 11 1878
(Month) (Day) (Year)

7. AGE: 41 Yrs. 4 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheepherder
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) austria

10. NAME OF FATHER: no information

11. BIRTHPLACE OF FATHER
(State or Country) " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ed Jackson
(Address) Kingman

15. Filed April 5 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
About March 2nd 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Verdict Coroners Jury.
Accidental death or possible suicide
Rifle shot Cause of death.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) N. S. Pate J of Peace ~~M. D.~~
4/4/1920 (Address) Kingman Idaho
acting Coroner.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shorkow — DATE OF BURIAL: 4-3 1920

20. UNDERTAKER: O J Brennan — ADDRESS: Shorkow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1020
Primary Registration District No. 2178
File No. 30173
Registered No. 178

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nina Jensen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan. (Month) 6 (Day) 1920 (Year)

7. AGE ..... Yrs. 3 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Alonzo Jensen

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Bessie Dinsdale

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alonzo Jensen
(Address) Ref.

15. Filed 5-5 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191..., that I last saw h... ✓ alive on ✓ 191..., and that death occured on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
1. Toxemia
2. .....
3. .....
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pustular Eczema
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C.C. Martin M. D.
May 1 1920 (Address) Rexburg Idaho

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ames	4/29 1920
20. UNDERTAKER	ADDRESS
John O'Reilly	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 30174
Registered No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lyman Emery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April 9 (Month) (Day) 1920 (Year)

7. AGE. Yrs. 10 mo. 15 da. If LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sugar City

10. NAME OF FATHER Wm Emery

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mary Ricks

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Emery Jr
(Address) Sugar

15. Filed 4-5 1920 J. Hespe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 9 1920, to Apr. 12 1920, that I last saw him alive on Apr. 11 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Convulsions

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. R. Shuyler M. D.
19 ..... (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar — DATE OF BURIAL: 4/13 1920

20. UNDERTAKER: John Phillips — ADDRESS: Rex.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 30175
Registered No. 48

1. PLACE OF DEATH.
County of Madison
City of Plano
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Burrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 10 (Day) 1900 (Year)

7. AGE: 19 yrs. 9 mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Plano Idaho

10. NAME OF FATHER: Geo E. Burrell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emily Ball

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Burrell
(Address) Plano

15. Filed 4/10 1920 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 4 (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/8 1920 to 4/10 1920 that I last saw her alive on 4/9 1920 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. L. Espe M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Plano
DATE OF BURIAL: 4/10 1920

20. UNDERTAKER: Rymer
ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 100
Primary Registration District No. 2178

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30176
Registered No. 47

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harris L. Rommenkamp

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Apr. (Month) 8 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 Ds. If LESS than 1 day how many ..... hrs. or 20 min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF FATHER: George L. Rommenkamp

11. BIRTHPLACE OF FATHER (State or Country): Hubbard Idaho

12. MAIDEN NAME OF MOTHER: Alta May Craig

13. BIRTHPLACE OF MOTHER (State or Country): Utah—Layton

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) George L. Rommenkamp
(Address) Rexburg Idaho

15. Filed 5-5 1920 G. G. Espe Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 8 1920, to Apr 8 1920, that I last saw him alive on Apr. 8 1920 and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ..... Yrs. ..... mos. 20 Min. ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Farley Nelson M. D.
4-8 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathrus — DATE OF BURIAL: 4/8 1920

20. UNDERTAKER: John Phillips — ADDRESS: Rex

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 30147
Registered No. 46

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Katrina Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. April 27 1844 (Month) (Day) (Year)

7. AGE: 75 Yrs. 11 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Andrew S. Swenson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Christina Palmer

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Rexburg

15. Filed 4/18 1920 — G. G. Estes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 18 1920, to 4/3 1920, that I last saw her alive on 4/1 1920, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Sclerosis Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) G. G. Estes M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Annis — DATE OF BURIAL: 4/8 1920

20. UNDERTAKER: J. Ryan — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 30178
Registered No. 43

1. PLACE OF DEATH.

County of Madison
City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME albert zollinger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. married (Write the word.)

6. DATE OF BIRTH. June (Month) 21 (Day) 1849 (Year)

7. AGE 70 Yrs. 9 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Gardener
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Switzerland

10. NAME OF FATHER Jacob zollinger

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Barbara Irminger

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Albert zollinger
(Address) Rexburg

15. Filed 5-5 1920 G. G. Espe Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 3rd (Day) 1920 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2nd 1920 191, to April 3rd 1920 191, that I last saw him alive on April 3rd 1920 191, and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Asthma

(Duration) — Yrs. 4 mos. — ds.

Contributory (Secondary) Senile debility

(Duration 2 yrs. — mos. — ds.

(Signed) Louis F. Rich M. D.

4/5 1920 (Address) Rexburg Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rexburg — **DATE OF BURIAL** 4/5 1920

20. UNDERTAKER John Phillips — **ADDRESS** Rexburg

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 180
Primary Registration District No. 2178
File No. 30179
Registered No. 44

County of Madison
City of Salem (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza Ann Nigley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 20 (Day) 1849 (Year)

7. AGE: 70 Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Ezekiah Cheney

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Lucy E. Hardy

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Clarence Nigley
(Address) Salem

15. Filed 5-5 1920 Geo Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1919, to Jan 2nd 1920, that I last saw her alive on Jan 2nd 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Exaustion

(Duration) — Yrs. 2 mos. — ds.

Contributory (Secondary) Arterio-sclerosis

(Duration) Several years. yrs. mos. ds.

(Signed) Lorin F. Rich M. D.

4/2 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: 4/3 1920

20. UNDERTAKER: John Phillips
ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

30181

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
(No. .... St.)

File No. 6
Registered No. 4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Fremont
City of Gifford

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray S. Cornwall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1920 (Year)

7. AGE: Yrs. 2 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... at home
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Jacob H Cornwall

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Thelma Bachus

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ray S Bachus
(Address) Gifford Idaho

15.
Filed 4 - 24 1920
E. E. Watts
Local Registrar

SVMS - YORK CO., PTRS. & SONS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2 - 18 1920, to 4 - 24 1920, that I last saw him alive on 4 - 24 1920, and that death occured on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Non viability

(Duration) Yrs. 2 mos. 6 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. E. Watts M. D.
4-24-1920 (Address) Gifford Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gifford Ida
DATE OF BURIAL: 4 - 25 1920

20. UNDERTAKER: W. E. Stoddard
ADDRESS: Gifford Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 93
Primary Registration District No. 2371
File No. 30182
Registered No.

1. PLACE OF DEATH
County of Nez Perce
City of Peck
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Louisa Rogers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Feb. (Month) 15 (Day) 1848 (Year)

7. AGE: 80 Yrs. 1 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Moses Black

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Martha Putney

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carrie J. Magill
(Address) Peck, Idaho.

15. Filed Feb. 16 1928 J. M. Tyle Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1903 to Feb. 16 1920 that I last saw her alive on Feb. 14 1920 and that death occurred on the date stated above, at 7:40 A M.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Tyle M. D.
2-16 1928 (Address) Peck Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: Feb 18 1920

20. UNDERTAKER: C J Wasson — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 93
Primary Registration District No. 2371
File No. 30183
Registered No.

1. PLACE OF DEATH
County of Nez Perce
City of Culdesac
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Cora A Boyd
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH fully, as directed in this form. Data should be plainly written. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 1 (Day) 1859 (Year)

7. AGE: 60 Yrs. 7 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Joseph H. Sumner

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): M T Boyd
(Address): Culdesac Ida

15. Filed Feb 7th 1920 Daniel Fyle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jany (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to Jan 31 1920, that I last saw h.. alive on Jan 28 1920, and that death occurred on the date stated above, at 1 a M.

The CAUSE OF DEATH* was as follows:
Heart Failure

(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Senility
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C V Smith M. D.
Jan 31 1920 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Culdesac Ida — DATE OF BURIAL: 2/1 1920

20. UNDERTAKER: W H Shaw — ADDRESS: Craigmont

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30184
Registered No. 387

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. White's Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virldon Henderson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

№ B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ..... 1..... (Month) (Day) (Year)

7. AGE: 8 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: scholar
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Va.

10. NAME OF FATHER: W. E. Henderson

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Lottie Blevins

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Henderson
(Address) Genatone

15. Filed May 6 1920 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 23 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18, 1920, to Feb 23 1920 that I last saw him alive on Feb 23 1920, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pyaemia (Septic)

..... (Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Ruptured appendix.
..... (Duration) ..... Yrs. ..... mos. 6 ds.

(Signed) E. L. White M. D.
Feb 23 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 6 days. In the State ..... yrs. ..... mos. 6 days
Where was disease contracted if not at place of death? Genatone
Former or usual residence do

19. PLACE OF BURIAL OR REMOVAL: Genatone Wx — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. Larsen — ADDRESS Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30185
Registered No. 388

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. White's Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No. 1009

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Horace Kilham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Sept 24 (Month) (Day) 1861 (Year)

7. AGE: 58 Yrs. 6 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sacramento Cal

10. NAME OF FATHER: Horace Kilham

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Laura Collins

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward D. Kilham
(Address) Portland Or

15. Filed May 6 1920 Evan E. Brown Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 23 1920, to March 30 1920
that I last saw h.. alive on March 30 1920
and that death occurred on the date stated above, at 8 45 P.M.
The CAUSE OF DEATH* was as follows:

Flu — Pneumonia
Lobar

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. 7 ds.

(Signed) Edgar P. White M. D.
3/31/1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Portland Ore — DATE OF BURIAL: ap 1920

20. UNDERTAKER: Finley Lon — ADDRESS: Portland

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30186
Registered No. 389

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred E. Nichols

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 6 (Day) 1920 (Year)

7. AGE: 46 Yrs. 6 Mos. 12 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: N. H. Nichols

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Emma Wolf

12. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. E. Nichols
(Address) Lewiston, Idaho

15. Filed May 8 1920 Rowan E. Brun Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 6th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1st 1920, to Apr 6th 1920, that I last saw h[im] alive on Apr 6th 1920, and that death occurred on the date stated above, at 1:15 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis from
Gangrenous Appendix

(Duration) ... Yrs. ... mos. 6 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) O. L. Lehman M. D.

1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	Apr 10 1920
20. UNDERTAKER	**ADDRESS**
C. J. Vassar	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30187
Registered No. 390

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 605 Fourth St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George McCloud

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Aug. 25 1856 (Month) (Day) (Year)

7. AGE: 63 Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: David G. McCloud

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Phoebe Chattaway

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miles G. Johnson
(Address) Lewiston, Idaho

15. Filed May 8 1920 Edward E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-6-1920, to 4-8-1920 that I last saw h[e] alive on 4-7-1920, and that death occurred on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Bronchiale

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Alley M. D.
19 ..... (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Ida
DATE OF BURIAL: May 19 1920

20. UNDERTAKER: Vassar
ADDRESS: Lewiston Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30188

Registration District No. 96

Primary Registration District No. 1609

Registered No. 391

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

(No. Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elvina Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept (Month) 28 (Day) 1914 (Year)

7. AGE: 5 Yrs. 6 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Umatilla

10. NAME OF FATHER Joe Moore

11. BIRTHPLACE OF FATHER (State or Country) Ida.

12. MAIDEN NAME OF MOTHER Edna Jones

13. BIRTHPLACE OF MOTHER (State or Country) Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jonas Moore

(Address) Lapwai Ida.

15. Filed May 8 1920 Susan E Brun
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1st 1920, to Nov. 12 1920, that I last saw h.. alive on Nov. 11 1920, and that death occurred on the date stated above, at 3 30/60 M.

The CAUSE OF DEATH* was as follows:

Cerebral meningitis.

..... (Duration) ..... Yrs. — mos. 10 ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. 14 ds.

(Signed) L.J. Perkins M. D.

11/12 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spaldings

DATE OF BURIAL: Nov. 1920

20. UNDERTAKER: Dawson

ADDRESS: Lewiston

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30189
Registered No. 392

Registration District No. 95
Primary Registration District No. 1009

1. PLACE OF DEATH
County of Nez Perce
City of
(No. Lewis Ave. Orchard St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bell King Crockett.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 28 (Month) (Day) 1863 (Year)

7. AGE: 57 Yrs. Mos. 17 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Mr. King

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ethyl M. Ellis.
(Address) Bakersdale Wn

15. Filed May 8 1920 Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20, 1920 to 4-13 1920 that I last saw h[illegible] alive on 4-13 1920 and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia as last
Fronting Contributory

(Duration) 7 Yrs. mos. ds.
Contributory (Secondary) Nervousness

(Duration) yrs. mos. ds.
(Signed) John N. Alley M. D.
4-22 1920 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 4-15-1920

20. UNDERTAKER: C. J. Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Allen

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30190
Registered No. 293

1. PLACE OF DEATH

County of Nez Perce
City or Lewiston
(No. 730 16th Ave St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Maud English

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	W.	Single (Write the word.)

6. DATE OF BIRTH Jan (Month) 23 (Day) 1920 (Year)

7. AGE Yrs. 2 Mos. 18 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Lewiston, Ida.

10. NAME OF FATHER C. P. English

11. BIRTHPLACE OF FATHER (State or Country) Lewiston Ida.

12. MAIDEN NAME OF MOTHER Maud Edna Farley

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. P. English
(Address) Lewiston Ida.

15. Filed May 8 1920 Susan E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/11 1920, to 4/13 1920 that I last saw her alive on 4/13 1920, and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Whooping cough

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) L. F. Forman M. D.
4/14 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston — **DATE OF BURIAL** 4/15 1920

20. UNDERTAKER Dexter — **ADDRESS** Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30191
Registered No. 394

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. #10, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvia Virginia Little

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 1 (Day) 1920 (Year)

7. AGE: 4 Yrs. 2 Mos. 14 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston, Ida.

10. NAME OF FATHER: F.A.Little

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Martha Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Freemond, Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): F.A Little
(Address): Lewiston, Ida.

15. Filed May 5 1920 Swan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/10 1920, to 4/15 1920
that I last saw h.. alive on 4/15 1920
and that death occurred on the date stated above, at 6.50 P.M.

The CAUSE OF DEATH* was as follows:
Whooping cough & Pneumonia

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) L F Inman M. D.
19... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Ida.
DATE OF BURIAL: Apr. 18-20

20. UNDERTAKER: .R.Merchant
ADDRESS: Clarkston

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30192
Registered No. 393

1. PLACE OF DEATH
County of Nezperce
City of Lewiston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Travis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE:
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: September (Month) 12th (Day) 1868 (Year)

7. AGE: 51 Yrs. 7 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lynn Co. Oregon

10. NAME OF FATHER: Elias Jennings

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mary Gladhill

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O W Travis
(Address) Lewiston Idaho

15. Filed May 8 1920 Roan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1919 to April 15 1920
that I last saw her alive on April 14 1920
and that death occurred on the date stated above, at 3:10 P.M.
The CAUSE OF DEATH* was as follows:
Brain tumor

(Duration) 8 Yrs. ..... mos. ..... ds.
Contributory (Secondary) —
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Paul W Johnson M. D.
4/16 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: Apr 18 1920

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30194
Registered No. 397

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. 322 1st Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stuart E Thompson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

6. DATE OF BIRTH: Mar (Month) 31 (Day) 1 (Year)

7. AGE: 48 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Printer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Geo. Thompson

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Amelia Peverley

13. BIRTHPLACE OF MOTHER (State or Country): Canada

I HEREBY CERTIFY THAT THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jay L Thompson
(Address) Lewiston Idaho
May 8 1920 Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 14th 1920, to Apr 21st 1920, that I last saw him alive on Apr 20th 1920, and that death occurred on the date stated above, at 1155P M.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis
(Duration) Yrs. mos. 30 ds.
Contributory TB Prostate Bladder etc
(Secondary)
(Duration) 3 yrs. mos. ds.

(Signed) O C Vassar M. D.
19 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: Ap 23 1920

20. UNDERTAKER: C J Vassar
ADDRESS: Lewiston

PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

...LY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
...be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
...properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30195
Registered No. 395

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. Sacred Heart Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Carson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. C. Reams
(Address) Lewiston Idaho

15. Filed May 8 1920 Susan E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 22nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 22nd 1920, to Apr 22nd 1920
that I last saw him alive on Apr 22nd 1920,
and that death occurred on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:

Uraemia Coma
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Nephritis Chr
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. C. Pearson M. D.
19..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 4.23.1920

20. UNDERTAKER: C. J. Vassar — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
File No. 30197
Registered No. 405

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. East Lewiston St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Fanny Carrago
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 15 (Day) 1886 (Year)

7. AGE: 32 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Tom Pericoda

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Angilo Maria Bronc

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) michael pecora
(Address)

15.
Filed May 6 1920 Susan E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 15 1920, to Apr. 22 1920, that I last saw h[illegible] alive on Apr. 22 1920, and that death occurred on the date stated above, at 9a. M.
The CAUSE OF DEATH* was as follows:

Bronchis pneumania.
(Duration) [illegible] Yrs. [illegible] mos. 2 ds.
Contributory (Secondary) Influenza.
(Duration) yrs. mos 8 ds.

(Signed) L. J. Perkins M. D.
4/22 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 4-23-1920

20. UNDERTAKER: C J Vassar — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. 0319 6th St.)

2. FULL NAME Mrs Ida Robinson

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30198

Registered No. 407

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Married

6. DATE OF BIRTH: June (Month) 14 (Day) 1870. (Year)

7. AGE: 50 Yrs. 10 Mos. 10 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: John Bateman

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Sarah A. Clifton

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W J Robison
(Address) 0319-6 St City.

15. Filed May 8 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/24 1920, to 4/24 1920 that I last saw her alive on 4/24 1920 and that death occurred on the date stated above, at 12:30 A.M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C J Duncan M. D.

19..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	4-26-1920
20. UNDERTAKER C. J. Duncan	ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Nez Perce

City of Lewiston

(No. 1445, Main St.)

Registration District No. 96

Primary Registration District No. 1009

File No. 30199

Registered No. 402

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John S Freng

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Widower

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE 94 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER — Freng

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Not-Known

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C J Freng

(Address) Lewiston Ida.

15. Filed May 6 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Susan E Bruce M. D.

4-29-1920 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Genesee	Apr 1920

20. UNDERTAKER	ADDRESS
C. J. Vasa	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30200

Registered No. 402

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert William Cormaney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	

6. DATE OF BIRTH

December (Month) 15th (Day) 1917 (Year)

7. AGE

2 Yrs. 4 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lewiston, Ida.

10. NAME OF FATHER A.J.Cormany

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Sara McCarthy

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A.J.Cormany

(Address) Lewiston, Ida.

15. Filed May 8 1920 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-27 1920, to 4-30 1920, that I last saw him alive on 4-20 1920, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Complications of Pleurisy

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Not Known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Walley M. D.

19 ..... (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida.	5/1 1920
20. UNDERTAKER	**ADDRESS**
H R Merchant	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. [illegible]

[illegible] OF DEATH

Registration District No. 97

Primary Registration District No. 2174

BOARD OF [illegible]
Bureau of Vital [illegible]

File No. 30201

Registered No. .....

1. PLACE OF DEATH.

County of Nez Perce

City of Lapwai

(No. ....., Ft. Lapwai Sanatorium St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown (Month) (Day) 1897 (Year)

7. AGE: 23 Yrs. ✓ Mos. ✓ ds.

IF LESS than 1 day how many ..... hrs. or ✓ min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: School boy.

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

9. BIRTHPLACE (State or Country): Montana.

10. NAME OF FATHER: Willis Taylor.

11. BIRTHPLACE OF FATHER (State or Country): Montana.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Richard Taylor.

(Address) ✓

15. Filed Apr. 20 1920 [signature illegible] Local Registrar

SYMS - YORK CO. PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 11. 1918, to Apr. 17. 1920, that I last saw him alive on Apr. 17 1920, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) Pulmonary Tuberculosis

.....(Duration 3 yrs. .....mos. .....ds.

(Signed) C. E. Sims M. D.

4/18/1920 (Address) Lapwai Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 7 mos. 6 days. In the State 1 yrs. 7 mos. 6 days

Where was disease contracted if not at place of death? Montana

Former or usual residence Poplar. Mont.

19. PLACE OF BURIAL OR REMOVAL: Poplar. Montana

DATE OF BURIAL: ✓ 191

20. UNDERTAKER: Norman Hamm

ADDRESS: Lapwai Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 30205
Registered No. 1

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Jenkins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1882 (Year)

7. AGE: 38 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: John Jenkins

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary Price

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry J. Hughes
(Address) Salt Lake City Utah

15. Filed Jan 3 1920 D. C. Ray Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 19..., to ... 19 20
that I last saw him alive on Jan 2 1920
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:

Intoxication probably from
Hardening of the arteries

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary)

.....(Duration) .....yrs.....mos.....ds.

(Signed) ..... M. D.
Jan 6 1920 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Ut
DATE OF BURIAL: Jan 7 1920

20. UNDERTAKER: D. E. Johnson
ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 2-35 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 30204
Registered No. 2

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephenmah Davis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING — WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Widowed)

6. DATE OF BIRTH: Dec (Month) 9 (Day) 1876 (Year)

7. AGE: 45 Yrs. [redacted] Mos. 20 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah - Boxelder

10. NAME OF FATHER: Samuel E Davis

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Poley Jones

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel E Davis
(Address) Malad, Idaho

15. Filed 1-7 1920 W Ray Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 3rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 3 1919, to Jan 3 1919, that I last saw h. alive on Jan 3 1919 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Wood alcohol poisoning

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Mauer M. D.
Jan 3 1919 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: S A Tem Ida. | DATE OF BURIAL: Jan 6 1920

20. UNDERTAKER: W C Johnson | ADDRESS: Malad

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Malad

(No. ..... St.)

Registration District No. 26

Primary Registration District No. 2069

File No. 30205

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jones Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~: widowed (Write the word.)

6. DATE OF BIRTH: April 24 (Month) (Day) 1845 (Year)

7. AGE: 74 Yrs. 9 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): So Wales

10. NAME OF FATHER: Thomas Jones

11. BIRTHPLACE OF FATHER (State or Country): So Wales

12. MAIDEN NAME OF MOTHER: Elizabeth Jenkins

13. BIRTHPLACE OF MOTHER (State or Country): So Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Evan Evans

(Address): Malad

15. Filed 1-28 1920 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 26 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:

General Debility

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. C. Ray M. D.

1/27 1920 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Jan 30 1920

20. UNDERTAKER: D M Thompson — ADDRESS: Brigham

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2064
File No. 30206
Registered No.

1. PLACE OF DEATH
County of Ada
City of Malad
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth L Reese

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) 7 (Day) 1919 (Year)

7. AGE: Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Ida

10. NAME OF FATHER: Lewis Reese

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Nellie M Abler

13. BIRTHPLACE OF MOTHER (State or Country): Calo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L L Reese
(Address) Malad

15. Filed Jan 28 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1920, to Jan 27 1920
that I last saw h[illegible] alive on Jan 26 1920
and that death occurred on the date stated above, at 2 9 M.
The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Alter M. D.
1-28 1920 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad
DATE OF BURIAL: 1/29 1920

20. UNDERTAKER: W. D. Thomas
ADDRESS: Malad Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 1069
File No. 30207
Registered No. 5

1. PLACE OF DEATH.
County of Oneida
City of St. Johns
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Nielson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 11 (Month) 11 (Day) 1919 (Year)

7. AGE ..... Yrs. 2 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) St Johns

10. NAME OF FATHER J.D. Nielson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Catherine Pierce

13. BIRTHPLACE OF MOTHER (State or Country) St Johns Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) J. D Nielson

15. Filed 2-6 1920 D C Ring Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1920, to Feb 5 1920, that I last saw him alive on Feb 4 1920, and that death occured on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows:
Septic pharyngitis,

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) none
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) R M Mauer M. D.
Feb 1920 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Johns — DATE OF BURIAL: 2-7 1920

20. UNDERTAKER: Woodland Furn. Co — ADDRESS: 2-5-20

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 30208
Registered No. 6

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary P. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH.
June (Month) 2 (Day) 1849 (Year)

7. AGE
70 Yrs. 8 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Wales

10. NAME OF FATHER: John Reynolds

11. BIRTHPLACE OF FATHER
(State or Country) Wales

12. MAIDEN NAME OF MOTHER: Catherine Williams

13. BIRTHPLACE OF MOTHER
(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. Reynolds
(Address) D. Reynolds

15.
Filed Feb 12 1920 D. C. Kay Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 9 1920, to Feb 11 1920, that I last saw h.r alive on Feb 11 1920, and that death occured on the date stated above, at 8 a.m. M.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) 2 Yrs. 6 mos. — ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) R. F. Mayer M. D.
Feb 11 1920 (Address) Malad, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho | DATE OF BURIAL: Feb 15 1920

20. UNDERTAKER: J. L. Benson | ADDRESS: Malad Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2C

County of Malad Oneida Primary Registration District No. 2069

File No. 30209

City of ..... (No. ..... St.)

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clyde Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Apr (Month) 9 (Day) 1919 (Year)

7. AGE ..... Yrs. 10 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Malad Oneida Co Ida

10. NAME OF FATHER Elvin Williams

11. BIRTHPLACE OF FATHER (State or Country) Oneida Co Ida

12. MAIDEN NAME OF MOTHER Annie C Jenkins

13. BIRTHPLACE OF MOTHER (State or Country) Oneida Co Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elvin P Williams

(Address) .....

15. Filed Feb 21 1920 D.C. Ray Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feby (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 16 1920, to Feby 20 1920, that I last saw him alive on Feby 20 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. Fallon M. D.

2-22 1920 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad — DATE OF BURIAL: Feb 23 1920

20. UNDERTAKER: J. G. Benson — ADDRESS: Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 20169
File No. 3029
Registered No. 0

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Mae Leigh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 12 (Day) 1910 (Year)

7. AGE: 9 Yrs. 4 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Idaho

10. NAME OF FATHER: Joe Leigh

11. BIRTHPLACE OF FATHER (State or Country): Malad Idaho

12. MAIDEN NAME OF MOTHER: Elizabeth Jones

13. BIRTHPLACE OF MOTHER (State or Country): Tamania Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Mae Edwards
(Address): Malad Idaho

15. Filed Feb 21 1920 D C Ray Local Registrar

SYMS - YORK CO., PTRS. & BKBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 4 1920, to Feby 20 1920, that I last saw h[illegible] alive on Feby 18 1920 and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia superinduced by Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
Feb 21 1920 (Address) J. F. Alton Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad, Idaho | DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: J. L. Benson | ADDRESS: Malad Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 3021
Registered No. 8

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Colton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1868 (Year)

7. AGE: 51 Yrs. 2 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Agriculture
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad City, Idaho

10. NAME OF FATHER: Joseph Colton

11. BIRTHPLACE OF FATHER (State or Country): Derbyshire, England

12. MAIDEN NAME OF MOTHER: Ellen Winfield

13. BIRTHPLACE OF MOTHER (State or Country): Derbyshire England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E W Colton
(Address) Malad City, Idaho

15. Filed Feb 26 1920 — J C Ray, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 12 1920, to Feb 24 1920, that I last saw h.. alive on Feb 23 1920, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis
(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R M Mauer M. D.
Feb 25 1920 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad.	Feb 26 1920
20. UNDERTAKER D. G. Johnson	ADDRESS Malad.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2026
File No. 30212
Registered No. 9

1. PLACE OF DEATH.
County of Oneida
City of Malad
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Guy Buhler Swenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 3rd (Day) 1918 (Year)

7. AGE: 2 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)... Child

9. BIRTHPLACE (State or Country) Logan Ut

10. NAME OF FATHER Charles Swenson

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake City

12. MAIDEN NAME OF MOTHER Lydia Buhler

13. BIRTHPLACE OF MOTHER (State or Country) Montpelier Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Charles Swenson

15. Filed Feb 28 1920 P.C. Rue Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920, to Feb 26 1920, that I last saw him alive on Feb 23 1920 and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Influenza - Broncio - Pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Influenza.
(Duration ..... yrs. ..... mos. 1 ds.

(Signed) W. M. Lamer M. D.
(Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan Utah — DATE OF BURIAL: Feb 29 1920

20. UNDERTAKER: J. G. Benson — ADDRESS: Malad Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRD - YORK CO., PTRS. & ENGS. 94859

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30213

Registered No. 10

1. PLACE OF DEATH.

County of Owyhee

City of Murphy

Registration District No. 26

Primary Registration District No. 2069

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Babe

6. DATE OF BIRTH: May (Month) 5 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ... hr. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) St Johns Idaho

10. NAME OF FATHER David Lewis

11. BIRTHPLACE OF FATHER (State or Country) St John Idaho

12. MAIDEN NAME OF MOTHER Maud Thomas

13. BIRTHPLACE OF MOTHER (State or Country) Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Lewis

(Address) Malad Idaho

15. Filed Mar 6 1920 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 5 1920 to March 5 1920, that I last saw h.. alive on March 5 1920, and that death occurred on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J F Allen M. D.

3-5 1920 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad	Mar 6 1920

20. UNDERTAKER	ADDRESS
D. P. Woodland	Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30214
Registered No. ____

1. PLACE OF DEATH
County of Owyhee
City of Murtaugh (No. ____ St.)
Registration District No. 26
Primary Registration District No. 2069
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank McDougall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (If widowed, write the word.): Single

6. DATE OF BIRTH: 12 (Month) 22 (Day) 1853 (Year)

7. AGE: 67 yrs. 1 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Boonville, NY

10. NAME OF FATHER Isaac McDougall

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Hannah M Jones

13. BIRTHPLACE OF MOTHER (State or Country) N Y

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elizabeth B. McDougall
(Address) .....

15.
Filed Mar 12 1920 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
3 (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 2 1920 to Mch 11 1920
that I last saw h in alive on Mch 11 1920
and that death occurred on the date stated above, at 8:40 P M.

The CAUSE OF DEATH* was as follows:
Uremic Poison

(Duration) ..... yrs. ..... mos. 11 ds.
Contributory (Secondary) Uremic Poison
(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) J. M. Terry M. D.
3/12 1920 (Address) Mallad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Petersburg Cem. | DATE OF BURIAL 1920

20. UNDERTAKER: J. Guy Benson | ADDRESS Mallad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Owyhee
City of Malad
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2064

File No. 30215
Registered No. 17
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: Mar (Month) 6 (Day) 1842 (Year)

7. AGE: 78 yrs. mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housewife.

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Wm Harris

11. BIRTHPLACE OF FATHER (State or Country) U.S.A.

12. MAIDEN NAME OF MOTHER Elezebith Hayes.

13. BIRTHPLACE OF MOTHER (State or Country) U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Winders
(Address) Malad

15.
Filed Mr 24 1920 D C Rae
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: March (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1920, to March 22 1920 that I last saw h[illegible] alive on March 22 1920 and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) 7 yrs. ..... mos. ..... ds.

(Signed) J F Alton M. D.
3-24 19 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad | DATE OF BURIAL: Mar 24 1920

20. UNDERTAKER: D. P. Woodland & J Guy Bourdon | ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

30216

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 13
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jenette Robert.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widd

6. DATE OF BIRTH
Apr. (Month) 8 (Day) 1920 (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..5.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Malad

10. NAME OF FATHER John M Robert

11. BIRTHPLACE OF FATHER (State or Country) U.S.A. Maine

12. MAIDEN NAME OF MOTHER Agnes McDonald

13. BIRTHPLACE OF MOTHER (State or Country) Ogden Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John M. Roberts
(Address) Malad Idaho

15.
Filed 4-9- 1920 D C. Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Apr. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 8 1920, to ..... 191..., that I last saw her alive on 4-8 1920, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C. Ray M. D.
4-9 1920 (Address) Malad.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad.	Apr. 11 1920

20. UNDERTAKER	ADDRESS
J J Benson	Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 30217
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agness M. Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Married

6. DATE OF BIRTH
March — 1878
(Month) (Day) (Year)

7. AGE
42 yrs. ..... mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Peery Utah

10. NAME OF FATHER Angus McDonald

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Agnes Young

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John M. Roberts
(Address) Malad Idaho

15.
Filed 4-8 1920 D C Ray
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 8 1920 to (191 ,
that I last saw h[illegible] alive on 4-8 1920
and that death occurred on the date stated above, at 9 A M.
The CAUSE OF DEATH* was as follows:
Post Partum Hemorrhage

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D C Ray M. D.
4-8 1920 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho | DATE OF BURIAL: Apr 11 1920

20. UNDERTAKER: J Benson | ADDRESS: Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2C
Primary Registration District No. 2069
File No. 30218
Registered No. 15

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Gilbert Thomas
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 10 (Day) 20 (Year)

7. AGE: ..... Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Malad Ida

10. NAME OF FATHER: Joseph R. Thomas

11. BIRTHPLACE OF FATHER (State or Country): Malad Ida

12. MAIDEN NAME OF MOTHER: Elizabeth Gilbert

13. BIRTHPLACE OF MOTHER (State or Country): Eden City Vt

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph R Thomas
(Address) Malad Ida

15. Filed 4-12 1920 D C Ray Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 11 1920, to Apr 12 1920, that I last saw h.im alive on 4-12 1920, and that death occurred on the date stated above, at 30 M.

The CAUSE OF DEATH* was as follows: Premature birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.

4-12 1920 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Ida	April 12 1920
20. ~~UNDERTAKER~~	**ADDRESS**
D.C. Johnson	Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2061
File No. 30219
Registered No. 16

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Warren Victor Beckstead
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: April (Month) 8 (Day) 20 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Malad Ida.

10. NAME OF FATHER: Warren Victor Beckstead

11. BIRTHPLACE OF FATHER (State or Country): Provo Utah.

12. MAIDEN NAME OF MOTHER: Jeremiah McKay.

13. BIRTHPLACE OF MOTHER (State or Country): Malad Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) mrs Jay McKay
(Address) Malad Ida.

15. Filed April 2 1920 D C Kay Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/10 1920, to 4/11 1920
that I last saw him alive on 4/11 1920,
and that death occurred on the date stated above, at 5-a M.
The CAUSE OF DEATH* was as follows:
Convulsions
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) unknown.
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) J. M. Kerr M. D.
4/11 1920 (Address) Malad Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Ida.	April 20 1920
20. UNDERTAKER D. E. Johnson	ADDRESS Malad

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
(No. ..... St.)

File No. 30220
Registered No. .....

1. PLACE OF DEATH
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret May Atkinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
Female	White	Single

6. DATE OF BIRTH July (Month) 15 (Day) 1918 (Year)

7. AGE 1 Yrs. 8 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Malad Ida.

10. NAME OF FATHER Frank A Atkinson

11. BIRTHPLACE OF FATHER (State or Country) Cherry Creek Ida.

12. MAIDEN NAME OF MOTHER Margaret J Hughes.

13. BIRTHPLACE OF MOTHER (State or Country) Tamanah Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank A Atkinson
(Address) Malad Idaho

15. Filed April 13 1920 D C Rail Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from apr 5 1920, to apr 12 1920
that I last saw her alive on apr 12 1920
and that death occurred on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows:

Heart failure following
Bronchopneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Fillon M. D.
4-13 1920 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Malad Ida. DATE OF BURIAL April 14 1920

20. UNDERTAKER D. E. Johnson ADDRESS Malad

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

File No. 30221

County of Oneida

City of Samaria (No. ..., ... St.)

Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Griffiths.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Female	White	Widowed

6. DATE OF BIRTH: Oct (Month) 14 (Day) 1839 (Year)

7. AGE: 80 yrs. 6 mos. 0 ds. (IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housework

9. BIRTHPLACE (State or Country) Wales.

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Daniels
(Address) ...

15. Filed 4-13 1920 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 11 1920 to ... 191..., that I last saw her alive on April 11 1920 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(Duration) ... yrs. ... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ... yrs. ... mos. ... ds.

(Signed) D C Ray M. D.

4-13 1920 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Samaria Idaho | DATE OF BURIAL: Apr. 15 1920

20. UNDERTAKER: J. Guy Benson | ADDRESS: Malad Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30222

Registered No. 19

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 24

Primary Registration District No. 2069

County of Oneida

City of Pleasantview (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glen Hadfield

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 17 (Day) 1920 (Year)

7. AGE: — yrs. 2 mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Pleasantview Idaho

10. NAME OF FATHER: Joseph Earl Hadfield

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER: Clio Hawks

13. BIRTHPLACE OF MOTHER (State or Country) Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Earl Hadfield

15. Filed April 18 1920 L C Kay Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1920 to April 17 1920 that I last saw h... alive on April 17 1920 and that death occurred on the date stated above, at 4P. M.

The CAUSE OF DEATH* was as follows:

Bronchio- Pneumonia.

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. T. Mauer M. D.

April 17 1920 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasantview Idaho | DATE OF BURIAL: April 20 1920

20. UNDERTAKER: J. G. Benson | ADDRESS: Malad Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Henderson Creek
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 36223
Registered No. 28
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ephriam Thomas Moon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
August (Month) 2 (Day) 1856 (Year)

7. AGE
63 yrs. 8 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Hugh Moon

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Janette Nicholes

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Annie Moon
(Address) Henderson Creek Oneida

15.
Filed April 18 1920 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 20 1920, to April 17 1920, that I last saw him alive on April 15 1920 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Alton M. D.
4-20 1920 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL
Cherry Creek Cemetery Apr. 20 1920

20. UNDERTAKER — ADDRESS
J. Guy Benson Malad Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 30284
Registered No.

1. PLACE OF DEATH.
County of Oneida
City of Malad (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John L Reynolds

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 12 (Day) 1867 (Year)

7. AGE: 32 yrs. 4 mos. 19 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Farmer & Business

9. BIRTHPLACE (State or Country) Wales

10. NAME OF FATHER David J Reynolds

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Sarah Lusk

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D L Reynolds
(Address) Malad Idaho

15. Filed May 3 1920 D C Ray Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) — 1 — (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 20 1920, to Apr 30 1920
that I last saw h. alive on Apr 30 1920
and that death occurred on the date stated above, at 1 PM.

The CAUSE OF DEATH* was as follows:
Chronic Endocarditis - aortic stenosis

(Duration) 18 yrs. mos. ds.
Contributory (Secondary) acute Cholecystitis
(Duration) yrs. mos. 30 ds.

(Signed) D C Ray M. D.
5/3 1920 (Address) Malad Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho | DATE OF BURIAL: May 4 1920

20. UNDERTAKER: J. Guy Benson | ADDRESS: Malad Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 30225
Registered No. 77

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Fannie Lew

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb 4 1863 (Month) (Day) (Year)

7. AGE: 57 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Arthur Silvester

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Fannie Mumford

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Lew
(Address) Samuels Ida

15. Filed 5/9 1920 D C Fay
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 6 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1920 to May 4 1920 that I last saw h[illegible] alive on May 6 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J F Alton M. D.

5-9 1920 (Address) Malad

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Johnson Ida — DATE OF BURIAL: May 9 1920

20. UNDERTAKER: D E Johnson — ADDRESS: Malad

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurred in a hospital or institution, give its NAME instead of street and number. If not in hospital or institution, give STREET AND NUMBER of residence. If outside city limits or village, give RURAL ROUTE NUMBER. If in a village, give name of village. If in a city, give WARD. If residence is same as place of death, so state. If transient or recent resident, give former residence. If non-resident, give usual residence. If death occurred on a train, give name of railroad and name of train. If death occurred on a vessel, give name of vessel and port to which she belongs. If in U. S. Military or Naval Service, give last legal residence, if civilian, and company, regiment, or vessel

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 26 — 30227

Primary Registration District No. 2069

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. ●

Registered No. 25

1. PLACE OF DEATH

County of Ingenda

City of Malad

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nat Jenkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov. (Month) 4 (Day) 1907 (Year)

7. AGE: 12 Yrs. 6 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Malad Idaho

10. NAME OF FATHER: Wm A. Jenkins.

11. BIRTHPLACE OF FATHER (State or Country): Wales.

12. MAIDEN NAME OF MOTHER: Sarah Jane Jones.

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Jenkins
(Address) Malad Idaho

15. Filed 5/19 20 — D G Ray — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 19 20 to May 16 19 20
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Asphyxia (accidental)

(Duration) 30 min yrs. mos. ds.
Contributory (Secondary) Falling in d acave
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R T Mann M. D.
5/19 1920 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad Idaho	May 20 1920
20. UNDERTAKER	ADDRESS
D. E. Johnson	Malad.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

26

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 2069
File No. 30228
Registered No. 24

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Lusk Williams

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: May (Month) 17 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country): Malad

10. NAME OF FATHER: Jinkin Williams

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth N Lusk

13. BIRTHPLACE OF MOTHER (State or Country): Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Williams
(Address) Malad

15. Filed 5/9 1920 L. D. Rey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 17 1920 to May 9 1920
that I last saw him alive on May 9 1920
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Convulsions.

(Duration) ..... yrs. ..... mos. 22 ds.

Contributory (Secondary) not known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kerns M. D.
5/9 1920 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad | DATE OF BURIAL: May 12 1920

20. UNDERTAKER: Guy Benson | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-15 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30229
Registered No. 60

1. PLACE OF DEATH.

Registration District No. 3
Primary Registration District No. 2005
County of Owyhee
City of Homedale (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lethra A. Huntley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single, Married, Widowed, Divorced~~ (write the word): Married
6. DATE OF BIRTH: Feb (Month) 1 (Day) 1877 (Year)
7. AGE: 42 Yrs. ..... Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Oregon
10. NAME OF FATHER: Saunders
11. BIRTHPLACE OF FATHER (State or Country): Illinois
12. MAIDEN NAME OF MOTHER: Dorothy Spencer
13. BIRTHPLACE OF MOTHER (State or Country): Iowa
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo Huntley
(Address) Homedale Ida
15. Filed 4-27- 1920 John L. Meyers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 25 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 24 1920, to Apr 25 1920, that I last saw her alive on Apr 24 1920, and that death occured on the date stated above, at 2 A M.
The CAUSE OF DEATH* was as follows:
Disease not known Supposed Cancer
..... (Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Neuralgia + Heart
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Samson Dobbin M. D.
4/26 1920 (Address) Homedale Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wilder Cemetery	[illegible] 1920
20. UNDERTAKER	ADDRESS
[illegible]	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Owyhee

City of Homedale

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5

Primary Registration District No. 2005

(No. ..... St.)

File No. 30230

Registered No. 63

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wallace Smith Vanderhoff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	white	Married

6. DATE OF BIRTH: March 19 (Month) (Day) 1853 (Year)

7. AGE: 67 Yrs. 1 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Caroline Vanderhoff
(Address) Caldwell, Homedale

15. (May) Filed 5-3- 1920

John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 30 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1917, to April / 1920 that I last saw h.. alive on April / 1920 and that death occurred on the date stated above, at 2.20 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary): Mitral Regurgitation

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) C. B. Branch M. D.

May 1920 (Address) Wilder Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wilder Idaho	May 3 1920
20. UNDERTAKER	**ADDRESS**
E. Peckham	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30231

Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Canyon

City of Nampa

2. FULL NAME Nancy Hewitt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: March 24 1847
(Month) (Day) (Year)

7. AGE: 73 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Abram West

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Otto Schmidt
(Address) Half Way, Oregon

15. Filed May 10 1920 John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 10 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Apr 1 1920 to May 10 1920
that I last saw her alive on Apr 1 1920
and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
General senility, ulcer of duodenum + contraction of pylorus
(Duration) several years

Contributory (Secondary) .....
(Duration) ... yrs ... mos ... ds.

(Signed) J. W. Gee M. D.

5/11 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Halfway Ore — DATE OF BURIAL: 5-12-1920

20. UNDERTAKER: W. Markham — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

41

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2130
Primary Registration District No.
File No. 30232
Registered No.

1. PLACE OF DEATH
County of Payette
City of Fruitland (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David L. Davis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: May (Month) 4 (Day) 1855 (Year)
7. AGE: 65 Yrs. 1 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: Davis
11. BIRTHPLACE OF FATHER (State or Country): Not Known ~~Harry Deere~~
12. MAIDEN NAME OF MOTHER: Mary Deere
13. BIRTHPLACE OF MOTHER (State or Country): not Known
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louise Ward
(Address) Fruitland Ida
15. Filed April 18 1920 C. C. Paxton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1919, to April 17 1920, that I last saw him alive on April 17 1920, and that death occurred on the date stated above, at 9 P M.
The CAUSE OF DEATH* was as follows:
Endocarditis
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) C. C. Paxton M. D.
4/18 1920 (Address) Fruitland Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Snoshone Ida — DATE OF BURIAL: Apr 19 1920
20. UNDERTAKER: J. A. Adair — ADDRESS: Payette Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30233

Registered No. 5

1. PLACE OF DEATH.

County of Payette

City of New Plymouth

Registration District No. 5

Primary Registration District No. 1009

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Verdie Manoe Smock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Boy

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Jan (Month) 17 (Day) 1920 (Year)

7. AGE: .....Yrs. 2 Mos. 14 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ada Co. Idaho

10. NAME OF FATHER Carlyle H. Smock

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Cora Lundstrom

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Cora Smock

(Address) New Plymouth

15. Filed Apr 2 1920 Wm I. Drysdale Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 26 1920, to Apr 1 1920, that I last saw h. im alive on " " 1920, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

.....(Duration) .....Yrs. .....mos. 7 ds.

Contributory (Secondary) Whooping Cough

.....(Duration .....yrs. .....mos. 3 wks ds.

(Signed) Wm I. Drysdale M. D.

4-2 1920 (Address) New Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New Plymouth

DATE OF BURIAL: 4-2 1920

20. UNDERTAKER: A. Meyer

ADDRESS: New Plymouth

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH — 30235

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2
Registered No. 99
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Power
City of Am. Falls.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 24
Primary Registration District No. 2072
(No. Bethany Hospital St.)
2. FULL NAME Ethelbert Lewis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Nov (Month) 28 (Day) 1882 (Year)

7. AGE: 37 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE: Woods Cross Utah
(State or Country)

10. NAME OF FATHER: Jeucha Lewis

11. BIRTHPLACE OF FATHER
(State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Josephine Wood.

13. BIRTHPLACE OF MOTHER
(State or Country): Not Known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Lillie Osterhout
(Address): Declo Idaho

15. Filed 4/29 1920 R. F. Mock
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12th 1920 to April 29 1920 that I last saw him alive on April 29th 1920 and that death occurred on the date stated above, at 4P. M.

The CAUSE OF DEATH* was as follows:
Carcinoma
(Duration) about 1 Yrs. mos. ds.
Contributory (Secondary) Acute encephalitis
(Duration) about 4 Yrs. mos. ds.
(Signed) Richard F. Mock M. D.
4/29 1920 (Address) American Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockland, Idaho — DATE OF BURIAL: May 1. 1920

20. UNDERTAKER: Arthur W Davis — ADDRESS: Am Falls Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30236
Registered No. 1

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special nformation.

Registration District No. 10
Primary Registration District No. 011
(No. Wallace Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Stein

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Widower

6. DATE OF BIRTH. December 25 1864
(Month) (Day) (Year)

7. AGE 57 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Switzerland

10. NAME OF FATHER J. V. Stein

11. BIRTHPLACE OF FATHER
(State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER
(State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Esther W. Thompson
(Address) Wallace, Idaho

15. Filed Jan 16 1920 F. L. Smith
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
January 15 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 26 1919 to Jan. 15 1920
that I last saw him alive on Jan. 15 1920
and that death occurred on the date stated above, at 3 p. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
.....
.....
.....(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Chas. T. Brown M. D.
.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace Idaho
DATE OF BURIAL Janu 18 1920

20. UNDERTAKER B. Mitchell
ADDRESS Wallace Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

City of Wallace

(No. Providence Hospital)

File No. 30237

Registered No. 2

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Michael Maher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

74 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Store Keeper and

(b) General nature of industry business, or establishment in which employed (or employer) Justice Peace

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Edmund Maher

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Margerite Doyle

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John F. Maher

(Address) Wallace Ida

15. Filed Jan 28 1920 J. F. Lucas
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

..... Jan 7 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19th 1920, to Jan 27th 1920, that I last saw him alive on Jan 27th 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 10 ds.

Contributory (Secondary) advanced age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Stone M. D.

19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	Jan 29 1920

20. UNDERTAKER	ADDRESS
Harry Thompson	Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30238

Registered No. 2

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1041

City of Wallace (No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Married

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

55 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... miner

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) North Carolina

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Olaf Erickson

(Address) Burke Ida

15.

Filed Jan 29 1920 W. L. Cooper
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

January 26 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/23/20 191 , to 1/26/20 191 , that I last saw h.. alive on 1/26/20 191 , and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Influenza - Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank C. Thorn M. D.

1/29/20 19 (Address) Wallace Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence Burke Idaho Shipped

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL

Mergers Falls Mont | Jan 29 1920

20. UNDERTAKER | ADDRESS

Harry Thompson | Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 104

File No. 30239

County of Shoshone

City of Wallace (No. Providence & Stoszlat St.)

Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James D. Young.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH

(Month) (Day) (Year)

7. AGE

64 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... miner

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER William Young.

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Amelia Coons.

13. BIRTHPLACE OF MOTHER (State or Country) Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed C Young

(Address) Wallace Ida

15.

Filed Feb 6 1920 F. L. Dunfey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feby 2nd 1920

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 25 1920 to Feb 2 1920

that I last saw h[illegible] alive on Feb 1 1920

and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) yrs. mos. 4 ds.

Contributory (Secondary) Compound Fract Left Arm

(Duration) yrs. mos. ds.

(Signed) D. H. Mowery M. D.

Feb 6 1920 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence..... Mullan Ida

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mullan Ida	Feby 7th 1920

20. UNDERTAKER	ADDRESS
Harry Thompson	Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30240

Registered No. 5

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Wallace Hospital St.)
Registration District No. 70
Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chris Miller (Christo Mileff)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	Single

6. DATE OF BIRTH
(Month) (Day) (Year)
1

7. AGE
26 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Bulgaria

10. NAME OF FATHER Milio Popoff.

11. BIRTHPLACE OF FATHER (State or Country) Bulgaria

12. MAIDEN NAME OF MOTHER unknown.

13. BIRTHPLACE OF MOTHER (State or Country) Bulgaria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marin Georgiff.
(Address) 228 Main Ave Spokane Wash

15. Filed Feb 13 1920 W. L. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
February (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1920, to Feb 11 1920, that I last saw h[im] alive on Feb 11 1920, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) 0 yrs. mos. 3½ ds.

Contributory (Secondary) Influenza

(Duration) 0 yrs. mos. 7 ds.

(Signed) Frank E. Freeman M. D.

19 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence Interstate Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	Feb 14 1920

20. UNDERTAKER	ADDRESS
Harry Thompson	Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30241

Registered No. 6

1. PLACE OF DEATH.

Registration District No. 7C

Primary Registration District No. 9 11

County of

City of

(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Philip Francis Tiddy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 27 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day laborer.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James P. F. Tiddy

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Martha Jane Trebilcock

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James P. F. Tiddy
(Address) Myers Falls Wash.

15. Filed Nov 10 1919 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: February (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1920, to Feb 15 1920 that I last saw h[illegible] alive on Feb 15 1920, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

[illegible]

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Feb 16 1920 (Address) Wallace, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence Myers Falls Washington

19. PLACE OF BURIAL OR REMOVAL: Myers Falls Wash. DATE OF BURIAL: Feby 17 1920

20. UNDERTAKER: Harry Thompson ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30242
Registered No. 7
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 70 11
(No. Wallace Hospital (St.))

2. FULL NAME Wm E. Haegle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: May (Month) 21 (Day) 1889 (Year)
7. AGE: 30 Yrs. 8 Mos. 29 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): So Dakota
10. NAME OF FATHER: Georg Haegle
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Barbara Henderson
13. BIRTHPLACE OF MOTHER (State or Country): Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Lloyd M. Scott
(Address): Spokane Wn.
15. Filed Feb 21 1920 F L Jennings Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 20 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from February 20 1920 to February 20 1920
that I last saw h. alive on February 20 1920.
and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Shock
Ruptured Bladder
Multiple Fractures of Pelvis etc
(Duration) .... Yrs. .... mos. .... ds.
Contributory (Secondary)
(Duration) .... Yrs. .... mos. .... ds.
(Signed) Wm. E. Jones M. D.
2/21 1920 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: July 22 1920
20. UNDERTAKER: Bruce & Norstell — ADDRESS: Wallace

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30213
Registered No. 8

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1911
(No. ..... Wallace Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Coleman Lamblin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Sept (Month) 23 (Day) 1886 (Year)
7. AGE: 33 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Oregon
10. NAME OF FATHER: D. L. Lamblin
11. BIRTHPLACE OF FATHER (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Estella Engle
13. BIRTHPLACE OF MOTHER (State or Country): Oregon
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. D. L. Lamblin
(Address) .....
15. Filed Feb 2 1920 F. L. Fenton Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: February (Month) 20 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1920 to Feb 20 1920
that I last saw him alive on February 20 1920
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
(a) Bronchio Pneumonia
.....
.....
.....(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Influenza
.....(Duration) ..... Yrs. ..... mos. 4 ds.
(Signed) Mary T. Lamb M. D.
2/21/20 19.... (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State ....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Weston Oregon
DATE OF BURIAL: Feby 22 1920
20. UNDERTAKER: W. D. Worstell
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 101
File No. 30244
Registered No. 9

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hospital / St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George albertini

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE
40 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... miner
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Austria Tyrol

10. NAME OF FATHER Stephen Albertinia

11. BIRTHPLACE OF FATHER (State or Country) Austria Tyrol

12. MAIDEN NAME OF MOTHER Rosa Rossi

13. BIRTHPLACE OF MOTHER (State or Country) Austria Tyrol

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Albert Albertinge
(Address) Wallace Idaho

15. Filed Feb 24 1920 O. F. L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Feb 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920, to Feb 22 1920
that I last saw h- alive on Feb 22 1920
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(Duration) yrs. mos. 6 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. ds.
(Signed) D Mowery M. D.
2/24 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Feb 25 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

30245

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1014
(No. Wallace Hospital)

File No.
Registered No. 10
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Victor Frankus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: January 14 (Month) (Day) 1876 (Year)

7. AGE: 44 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mucker
(b) General nature of industry business, or dstablishment in which employed (or employer): miner

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Joe Frank

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Barbara Markota

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Estha Simpson
(Address) Wallace Idaho

15. Filed Feb 24 1920 F L Jenks Local Registrar

FEB 24 1920

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby (Month) 22nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920 to Feb 22 1920 that I last saw h[illegible] alive on Feb 22 1920 and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
1 Fracture Femur - Fracture Clavicle -
2 Cerebral paralysis - Cerebral Hemorrhage

(Duration) yrs mos 4 ds.

Contributory (Secondary)
(Duration) yrs 1 mos ds.

(Signed) Frank C Jones M. D.
(Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence Indefinite Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Feby 25 1920

20. UNDERTAKER: Harry Thompson
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 4011
File No. 30246
Registered No. 17

1. PLACE OF DEATH
County of Shoshone
City of Wallace
(No. 602 Pearl Street St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) 5 (Day) 1870 (Year)

7. AGE: 49 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Joe Visintainer

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Albina

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jos. A Brown
(Address) Wallace Idaho

15. Filed Feb 26 1920 F. L. Zumwalt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2/22 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/12 1920, to 2/22 1920, that I last saw h[illegible] alive on 2/22 1920, and that death occured on the date stated above, at 6:20 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary) Pneumonia

(Duration) 2 Yrs. mos. 1 ds.

(Signed) L. Mowery M. D.
2/26 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Feby 26 1920

20. UNDERTAKER: Drum & Mostell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1901
File No. 30217
Registered No. 12

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Terrel L. Gillenwaters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH.
(Month) (Day) 1 (Year)

7. AGE
30 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... miner
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Tenn

10. NAME OF FATHER A. C. Gillenwaters

11. BIRTHPLACE OF FATHER
(State or Country) Tenn.

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER " "
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sister Superior
(Address) Providence Hospital Wallace, Idaho.

15. Filed Feb 27 1920 F. L. Jenn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2/25
(Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/20, 191, to 2/25 1920, that I last saw h-m alive on 2/25 1920 and that death occured on the date stated above, at 3P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
(Duration) Yrs. mos. ds.
Contributory (Secondary) Influenza
(Duration) 2 Yrs. mos. 3 ds.

(Signed) D. Mowery M. D.
2/26 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Maryville, Tennessee	Feby 28 1920

20. UNDERTAKER Bruce G. Nordtell ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30248

Registered No. 13

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1011

(No. Wallace Hospital St.)

2. FULL NAME Chris Frostad

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: August 22 1880
(Month) (Day) (Year)

7. AGE: 39 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Rasmus Frostad

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Helen Gimmestad

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Estelle Thompson

(Address) [illegible]

15. Filed Feb 26 1920 F. L. Jenks
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feby 20 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18 1920 to Feb 20 1920 that I last saw h. alive on Feb 20, 1920 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia -

(Duration) 2 yrs. mos. 4 ds.

Contributory (Secondary) Influenza

(Duration) 4 yrs. 1 mos. 8 ds.

(Signed) Harry L Thompson M. D.

2/25 1920 (Address) Wallace Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence Wallace Idaho Shipped

19. PLACE OF BURIAL OR REMOVAL: Duluth Minn

DATE OF BURIAL: Feb 28 1920

20. UNDERTAKER: Harry Thompson

ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30249

Registered No. 14

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of Shoshone

City of Wallace (No. Providence Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Manning

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

72 yrs. — mos. — ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Railroad Engineer

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Minn

10. NAME OF FATHER unknown

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Cavanaugh

(Address) Providence Hospital

15. Filed Feb 28 1920 F. L. Jones
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Feb (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191 ..., to Feb 26 1920

that I last saw him alive on Feb 25 1920

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

Senile gangrene

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. L. Jones M. D.

19 ..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	Feb 29 1920

20. UNDERTAKER	ADDRESS
Harry Thompson	Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1901
(No. 212 Cedar St. St.)

File No. 30250
Registered No. 12

1. PLACE OF DEATH
County of Shoshone
City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther Marguerette Hall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 2 (Day) 1906 (Year)

7. AGE: 13 Yrs. 5 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): At School

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Julius P Hall

11. BIRTHPLACE OF FATHER (State or Country): Cal.

12. MAIDEN NAME OF MOTHER: Marguerette Bradley

13. BIRTHPLACE OF MOTHER (State or Country): Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Julius P. Hall
(Address) Wallace, Idaho.

15. Filed March 1920 F. L. Sanders Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 2/28 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/13 1920, to 2/28 1920, that I last saw her alive on 2/27 1920, and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Influenza & Pneumonia

(Duration) yrs. mos. 13 ds.

(Signed) D. S. Mowery M. D.

2/28 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho
DATE OF BURIAL: Mar 2 1920

20. UNDERTAKER: Bruce & Mortell
ADDRESS: Wallace Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 30251
Registered No. 16

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Porritt

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov 11 1837 (Month) (Day) (Year)

7. AGE: 82 yrs. 3 mos. 16 ds.
IF LESS than 1 day how many .....hrs. or .....mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerical
(b) General nature of industry business, or dstablishment in which employed (or employer): Railway

9. BIRTHPLACE (State or Country): York State

10. NAME OF FATHER: Robert Porritt

11. BIRTHPLACE OF FATHER (State or Country): Yorkshire England

12. MAIDEN NAME OF MOTHER: Elizabeth Dawson

13. BIRTHPLACE OF MOTHER (State or Country): Yorkshire England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mortou Webster
(Address) Box 184, Wallace, Ida

15. Filed Mch 1 1920 F. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2/27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April, 1916 to Feb 27 1920
that I last saw h[illegible] alive on Feb 27 1920
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Senile Meningitis
(Duration) 4 yrs. mos. 3 ds.
Contributory (Secondary) Senile Dementia
(Duration) 3 yrs. mos. ds.
(Signed) D. B. Mowery M. D.
2/28 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence: Wallace Idaho Shipped

19. PLACE OF BURIAL OR REMOVAL: Fargo North Dakota | DATE OF BURIAL: Mar. 2 1920

20. UNDERTAKER: Harry Thompson | ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30252

Registered No. 17

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Wallace Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 1011

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Nickolovich (Mihaljevich)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE: 30 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Sam Nickolovich

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Esther Simpson
(Address) Wallace Hospital

15. Filed Mch 16 1920 F. L. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from February 23 1920 to March 10 1920 that I last saw h[illegible] alive on March 10 1920 and that death occurred on the date stated above, at [illegible] P. M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) 2 yrs. mos. 9 ds.

Contributory (Secondary): Lobar Pneumonia.

(Duration) 1 yrs. 4 mos. 7 ds.

(Signed) Thomas G. Thomas M. D.

3/16/20 19 (Address) Wallace Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence: Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Mar. 17 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30253

Registered No. 19

Registration District No. 70

Primary Registration District No. 916

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harvey Ross Ramey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 9 (Day) 1906 (Year)

7. AGE: 14 Yrs. 1 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): [redacted] Wash

10. NAME OF FATHER: James H. Ramey

11. BIRTHPLACE OF FATHER (State or Country): Vir

12. MAIDEN NAME OF MOTHER: L O Hutchinson

13. BIRTHPLACE OF MOTHER (State or Country): Vir

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James H. Ramey

(Address) Osburn Idaho

15. Filed Mch 21 1920 F. L. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 23 1920, to March 26 1920, that I last saw h. alive on March 26 1920, and that death occured on the date stated above, at 1 p. M.

The CAUSE OF DEATH* was as follows:

General Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Suppurative Appendicitis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm T. Smith M. D.

3/29/20 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Ida, — DATE OF BURIAL: Mch 30 1920

20. UNDERTAKER: B. Worstell — ADDRESS: Wallace

BYMS - YORK CO., PTRS. & BDRS. 24653

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30254

Registered No. 19

Registration District No. 20

Primary Registration District No. 1911

(No. Providence Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

2. FULL NAME Stanford Clarence Parks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Dec (Month) 1 (Day) 1919 (Year)

7. AGE: 0 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Clarance Parks

11. BIRTHPLACE OF FATHER (State or Country): Miss

12. MAIDEN NAME OF MOTHER: Augusta Wells

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence Parks

(Address) Burke Ida

15. Filed Mch 27 1920 F. L. Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 13 1920 to Mch 17 1920, that I last saw him alive on Mch 17 1920 and that death occured on the date stated above, at 1:30 P M.

The CAUSE OF DEATH* was as follows:

Coma

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) L Bottolfsen M. D.

(Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace, Idaho. DATE OF BURIAL: Mch 23 1920

20. UNDERTAKER: Bruce G. Worstell ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30255
Registered No. 29

1. PLACE OF DEATH.
County of Shoshone
City of Wallace (No. Providence Hosp. St.)
Registration District No. 70
Primary Registration District No. 10 W
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna E. Malmquist
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Aug (Month) 7th (Day) 1872 (Year)
7. AGE: 47 Yrs. 7 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Kansas
10. NAME OF FATHER: David Moore
11. BIRTHPLACE OF FATHER (State or Country): Ill.
12. MAIDEN NAME OF MOTHER: Maria Umphrey
13. BIRTHPLACE OF MOTHER (State or Country): Ill.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Malmquist
(Address) Wallace Idaho
15. Filed Mar. 27 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 23 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Mch 4 1920, to Mch 23 1920, that I last saw her alive on Mch 23 1920 and that death occured on the date stated above, at 10 30 P M.
The CAUSE OF DEATH* was as follows:
Acute hypostatic pneumonia
Influenza Pneumonia
(Duration) Yrs. mos. 19 ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) L B Strachan M. D.
3-27 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: 3/28 1920
20. UNDERTAKER: L.L. Morstad
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

Dr Hammer

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30256
Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1911

City of Wallace (No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wenceslava E Zorna

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	married

6. DATE OF BIRTH. March 28 1887 (Month) (Day) (Year)

7. AGE 32 Yrs. 11 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Portland Ore

10. NAME OF FATHER Blalock

11. BIRTHPLACE OF FATHER (State or Country) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joe Gerna

(Address) Gem Ida.

15. Filed ..... 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 26 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 16 1920 to Mch 26 1920, that I last saw h[illegible] alive on March 26 1920, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Ac. Cardiac Dilitation

(Duration) [illegible] Yrs. mos. ds.

Contributory (Secondary) & Pulmonary Edema -

(Duration) yrs. 1/2 mos. ds.

MAR 27 1920

(Signed) Girard C. Kaufman M. D.

(Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Wallace, Ida. **DATE OF BURIAL** Mch 30 1920

20. UNDERTAKER D.L. Mordtell. **ADDRESS** Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PYRS. & BOOS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1016
(No. Providence Hospital)

File No. 30257
Registered No. 23

2. FULL NAME Theresa Bardelli

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	White	Single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
15 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student.
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Vermont

10. NAME OF FATHER Ambrose Bardelli

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Caterina Albanola

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Joseph Cauley
(Address) Burke Idaho

15. Filed Mch 31 1920 F. L. Tuttle Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1919, to March 30 1920
that I last saw her alive on March 29 1920
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 1 yrs. mos. ds.

Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) D. Mowery M. D.
3/31 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Mar 31 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30258

Registered No. 24

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 20

Primary Registration District No. 6/1

(No. Providence Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pietro Colombotto

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 9 (Day) 1886 (Year)

7. AGE: 33 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): Mch 24 1920

12. MAIDEN NAME OF MOTHER: Maria Colombotto

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) F. L. Jungley

(Address) Wallace Ida

15. Filed Mch 29 1920 F. L. Jungley Local Registrar

BYRNE - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch. (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1919, to Mch 29 1920, that I last saw him alive on Mch 29 1920 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. L. Jungley M. D.

(Address) Mch 29 1920

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: April 1 1920

20. UNDERTAKER: J. D. Moulton — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7C
Primary Registration District No. 1211
File No. 30259
Registered No. 95

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Edna Dunkle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Sept (Month) 9th (Day) 1917 (Year)

7. AGE: 2 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Raymond A. Dunkle

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Augusta E. Peterson

13. BIRTHPLACE OF MOTHER (State or Country): North Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address) M A Dunkle Osburn Idaho

15. Filed Apr 17 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/11/20 191..., to 4/11/20 191..., that I last saw h[illegible] alive on 4/11/20 191..., and that death occured on the date stated above, at 11:30 P. M.
The CAUSE OF DEATH* was as follows:
Drowning Lapse -
(Duration) ? Yrs. / mos. 6 ds.
Contributory (Secondary) Fract. degree burns of body
(Duration) ? yrs. ? mos. 6 ds.
(Signed) Ernest G. Stokes M. D.
(Address) Wallace Idaho
APR 13 1920

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Ida Ko.
DATE OF BURIAL: 4/13th 1920.
20. UNDERTAKER: B G Mostell
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30260

Registered No. 2 to

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 1011

(No. Wallace Hospital St.)

2. FULL NAME Charles B Nelson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: May (Month) 18 (Day) 1880 (Year)

7. AGE: 39 yrs. mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Gust Nelson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Beatrix Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wallace Hospital
(Address) By Esther Simpson

15. Filed Apr 21 1920 F. R. Lee Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1920, to April 18 1920, that I last saw him alive on April 18 1920 and that death occurred on the date stated above, at 7 p M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Mary E. Smith M. D.

4/21/1920 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence: Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: Apr 22 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

Dr Mowery

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30201

Registered No. 27

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Providence Hosp. St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70

Primary Registration District No. 11014

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Whitney Earl Decker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Nov (Month) 19 (Day) 1884 (Year)

7. AGE 35 Yrs. 5 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Mine Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)..... quartz mine

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER A. A. Decker

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs N. F. Decker

(Address) Mullan Ida

15. Filed Apr 30 1920 F. L. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 28 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14 1920 to April 28 1920, that I last saw h.. alive on April 28 1920 and that death occured on the date stated above, at 4A M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Dr Mowery M. D.

April 28 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mullan Ida	4/30 1920
20. UNDERTAKER	ADDRESS
K. E. Worstell	Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30262

Registered No. 35

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Mullan
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122
Primary Registration District No. 2100
(No. Morning Mine Str.)

2. FULL NAME L. C. Palmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE
41 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Motorman
(b) General nature of industry business, or dstablishment in which employed (or employer) Mining

9. BIRTHPLACE (State or Country) not given

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. G. Donahoe
(Address) Wallace Ida

15. Filed 4/16 1920 H. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 16 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Electrocuted at Morning Mine
Shoshone County State of Idaho

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo W Walker M. D.
19 (Address) Justice of the Peace Wallace Precinct No 4

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Mullan Ida

19. PLACE OF BURIAL OR REMOVAL Spokane Wash. DATE OF BURIAL Apr 19 1920

20. UNDERTAKER Stacy Thompson ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Burke
(No. Residence St.)

Registration District No. 122
Primary Registration District No. 2700
File No. 30263
Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert James Thorton

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	Married

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE
30 yrs. 30 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Repair man in
(b) General nature of industry business, or dstablishment in which employed (or employer) mill

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER James Thorton

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Ann Campbell

13. BIRTHPLACE OF MOTHER
(State or Country) Lee Co Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Workelam
(Address) Burke Ida

15.
Filed April 22 1920 H. C. Mowe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1920 to April 13 1920
that I last saw h alive on April 13 1920
and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:
Scarlet Fever

(Duration) yrs. mos. 3 ds.

Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) L B Hawkshaw M. D.
April 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Apr. 25 1920

20. UNDERTAKER: Harry Thompson
ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 1200
File No. 30264
Registered No. 37

1. PLACE OF DEATH.
County of Shoshone
~~City of~~ North Fork
(No. North Fork River St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Reynolds

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 38 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Day Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): Woodsman

9. BIRTHPLACE (State or Country): not given

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. F. Doles
(Address) North Fork

15. Filed May 1 1920 H. C. Mower Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 30th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
"Accident" Struck by falling tree

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. N. Walker M. D.
Justice of the Peace Wallace Precinct No 2
May 1 1920 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Coeur D'Alene City Ida

19. PLACE OF BURIAL OR REMOVAL: Coeur D'Alene City Ida | DATE OF BURIAL: May 1 1920

UNDERTAKER: G. Harry Thompson | ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30265
Registered No. 38

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Black Bear Ida St.)
Registration District No 122
Primary Registration District No 1700
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther Hollandsworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feby (Month) 23 (Day) 1 (Year)

7. AGE: 15 Yrs. 1 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: J. L. Hollandsworth

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Rose Clark

13. BIRTHPLACE OF MOTHER (State or Country): No Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address)

15. Filed May 7 1920 H. C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2nd 1919, to May 2nd 1920, that I last saw her alive on May 2nd 1920, and that death occured on the date stated above, at 1.0 P M.

The CAUSE OF DEATH* was as follows:

Uremia

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Parenchymatous nephritis

(Duration 4 yrs. mos. ds.

(Signed) Mary T. Smith M. D.

5/4/20 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: May 5 1920

20. UNDERTAKER: B. Moretti — ADDRESS: Wallace

BYNS - YORK CO., PTRS. & BDRS. 24853

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30266

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 173
Primary Registration District No. 7701
(No. ....., St.)

File No. 71
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Arthur Laird

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH
Nov (Month) 4 (Day) 1897 (Year)

7. AGE
22 yrs. 5 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Student
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Minnesota

10. NAME OF FATHER Edward Laird

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Rose Marrow

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Laird.
(Address) Northport Wash.

15.
Filed 4/21 1920 Jno S Leslie
Local Registrar

MEDICAL CERTIFICATE OF DEATH. Leslie

16. DATE OF DEATH
Apr (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 19 1920, to Apr 20 1920, that I last saw him alive on Apr 20 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno. S Leslie M. D.
Apr 21 1920 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Northport Wash. DATE OF BURIAL: Apr 23 1920

20. UNDERTAKER: M. C. Thornhill ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M-1-16-12

CERTIFICATE OF DEATH

30267

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 123

Primary Registration District No. 7701

File No. 72

County of Shoshone

City of Kellogg (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joyce Lenore Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept 25, 1918 (Month) (Day) (Year)

7. AGE: 1 yrs. 6 mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Floyd A Fisher

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Newman

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Floyd A Fisher
(Address) Kellogg Idaho

15. Filed 4/21 1920 W. J. Fro, S Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 19 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 12 1920, to Apr 19 1920, that I last saw h-r alive on Apr 17 1920, and that death occurred on the date stated above, at 5.4 M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of bowel

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Enteritis

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) W. E. Lindsay M. D.

4/21 1920 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg — DATE OF BURIAL: Apr 21 1920

20. UNDERTAKER: M. C. Thornhill — ADDRESS: Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30268

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 17
Registered No.

1. PLACE OF DEATH
County of Teton
City of Tetonia
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esta Hill
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb 14 1920 (Month) (Day) (Year)

7. AGE: Yrs. 0 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tetonia Idaho

10. NAME OF FATHER: John M. Hill

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Fry Dixon

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John M. Hill
(Address) Tetonia, Idaho

15. Filed April 29th 1920 Martha Marker
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 19 1920, to Apr 27 1920 that I last saw h[illegible] alive on Apr 27 1920 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Martin M. D.
19..... (Address) Driggs, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tetonia Idaho
DATE OF BURIAL: 4/29 1920

20. UNDERTAKER: W J King
ADDRESS: Driggs Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 30269

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Teton

City of Felt

Registration District No. 77

Primary Registration District No. 2175

(No. ....., ... St.)

File No. 16

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Perly Renneau

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 23 (Day) 1883 (Year)

7. AGE: 37 Yrs. ..... Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Domestic

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER J Renneau

11. BIRTHPLACE OF FATHER (State or Country) Dont know

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo W Bamlet

(Address) Felt Idaho

15. Filed April 14 1920 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw her alive on 17 th March 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Triage to Death

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. Pearson Coroner M. D.

19..... (Address) Box 136 Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho.

DATE OF BURIAL: Mar 20 1920

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24854

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30272

Registered No. ____

1. **PLACE OF DEATH**

County of Jerome

City of Eden

(No. ____ St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 2085

2. **FULL NAME** John B. Kelly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED, OR DIVORCED** (Write the word) Single

6. **DATE OF BIRTH** ~~March~~ Feb. 25 (Month) (Day) 1920

7. **AGE** Yrs. 1 Mos. 17 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work ____

(b) General nature of industry, business or establishment in which employed (or employer) ____

9. **BIRTHPLACE** (State or Country) Idaho

10. **NAME OF FATHER** Carl G. Kelly

11. **BIRTHPLACE OF FATHER** (State or Country) Oklahoma

12. **MAIDEN NAME OF MOTHER** May Waller

13. **BIRTHPLACE OF MOTHER** (State or Country) Kansas

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Earl T. Kelly

(Address) ____

15. Filed April 12 1920 John A. Caughlan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Apr. 11 (Month) (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 4/9 1920 to 4/11 1920

that I last saw him alive on 4/11 1920

and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ____ Yrs. ____ mos. 2 ds.

Contributory (Secondary) —

(Duration) ____ yrs. ____ mos. — ds.

(Signed) W. P. Scroggs M. D.

4/12 1920 (Address) Eden, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. **PLACE OF BURIAL OR REMOVAL** Twin Falls — **DATE OF BURIAL** 4/12 1920

20. **UNDERTAKER** J. G. Sorenson — **ADDRESS** Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51067

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 1085
File No. 30273

1. PLACE OF DEATH
County of Twin Falls
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur P Hansen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan 1 1
(Month) (Day) (Year)

7. AGE: 23 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Peter Hansen

11. BIRTHPLACE OF FATHER (State or Country): Bergen Norway

12. MAIDEN NAME OF MOTHER: Agentha Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Bergen Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otto M. Hansen
(Address) Ogden, Utah

15. Filed April 29 1920 John Laughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 29 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1920 to April 29 1920 that I last saw h.im alive on April 29 1920 and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Appendicitis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jos Boyd M. D.
April 30 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J E Dewitt
ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30274
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Doris Bryant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: oct 12 (Month) (Day) 1895 (Year)

7. AGE: 25 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Henry walter

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Gertrude Silvernagle

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. A. Bryant
(Address) 2627 N. Harding ave Chicago Ill

15. Filed April 27 1920 John F. Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1920, to April 27 1920 that I last saw h.er alive on April 27 1920 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) D. H. Boyd M. D.
4/27 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill | DATE OF BURIAL 19

20. UNDERTAKER: F. E. Wurtt | ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30275
Registered No.

1. PLACE OF DEATH. Registration District No. 37
County of Twin Falls Primary Registration District No. 1085
City of " " (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John I Ward

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: June (Month) 29 (Day) 1857 (Year)

7. AGE: 62 yrs. 10 mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: News Dealer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Thomas Ward

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Susana Stokes

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ida F. Ward
(Address) Twin Falls Ida

15.
Filed April 27 1920 John Haughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 6 1920, to Apr 21 1920, that I last saw him alive on Apr 21 1920, and that death occurred on the date stated above, at 6.30 P. M.

The CAUSE OF DEATH* was as follows:

Smallpox

(Duration) yrs. mos. ds.

Contributory (Secondary) Chr. nephritis

(Duration) yrs. mos. ds.

(Signed) H W Shondel M. D.

4/22 1920 (Address) Twin Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 4/22 1920

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls

BYNS - YORK CO., PTRS. & BORS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30276

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1088
(No. ____, ____ St.)

2. FULL NAME Lyman Morris Dow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	White	Married

6. DATE OF BIRTH: Jan (Month) 8 (Day) 1864 (Year)

7. AGE: 56 yrs. 3 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer): Owner

9. BIRTHPLACE (State or Country): Nile, Ontario Canada

10. NAME OF FATHER: Kenneth Morris

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary Dow

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank R. Morris
(Address) Buffalo N.Y.

15. Filed April 27 1920 John A. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: April (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1920, to April 13 1920;
that I last saw h. m. alive on April 13 1920
and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Embolism — Duodenitis
(Duration) ____ yrs. ____ mos. ____ ds.
Contributory Pleurisy & Pneumonia +
(Secondary) Strept. Coccus Guardiae
(Duration) ____ yrs. ____ mos. 12 ds.
(Signed) Duncan P. McTavish M. D.
4/25 1920 (Address) Twin Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: 4/18 1920

20. UNDERTAKER: J. J. Grossman | ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**
County of Twin Falls
City of ....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ...., ..., St.)

File No. 30279
Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Fred L Leiser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Married

6. **DATE OF BIRTH** April 13 (Month) 1878 (Day) (Year)

7. **AGE** 42 Yrs. .... Mos. 4 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: retired operator
(b) General nature of industry, business or establishment in which employed (or employer): ....

9. **BIRTHPLACE** (State or Country) Ohio

10. **NAME OF FATHER** Fred Leiser

11. **BIRTHPLACE OF FATHER** (State or Country) Switzerland

12. **MAIDEN NAME OF MOTHER** Mary Starer

13. **BIRTHPLACE OF MOTHER** (State or Country) France

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Wm Fiocht
(Address) Twin Falls Ida

15. Filed Apr 21 1920 John Faucht Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** April (Month) 19 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from July — 1919, to April 18 1920
that I last saw h— alive on April 18 1920
and that death occurred on the date stated above, at 5 00 P.M.
The **CAUSE OF DEATH*** was as follows:
Brain tumor
.... (Duration) 2 Yrs. .... mos. .... ds.
Contributory (Secondary) ....
.... (Duration) .... yrs. .... mos. .... ds.
(Signed) H Worden M. D.
April 20 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death? ....
Former or usual residence ....

19. **PLACE OF BURIAL OR REMOVAL** Twin Falls Idah — **DATE OF BURIAL** 4 22 1920

20. **UNDERTAKER** L O Everett — **ADDRESS** Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No.
Registered No. 30280

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bert Rondall Stevens
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 27 (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: L. F. Stevens

11. BIRTHPLACE OF FATHER (State or Country): Ore

12. MAIDEN NAME OF MOTHER: Stella Bowsbey

13. BIRTHPLACE OF MOTHER (State or Country): Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): L. Stevens
(Address): Acequia Idaho

15. Filed Apr. 14 1920 John F. Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 — 17 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 14th 1920 to Apr 17 1920 that I last saw him alive on Apr 17 1920 and that death occurred on the date stated above, at 2:00 P.M.
The CAUSE OF DEATH* was as follows:
Peritonitis following perforated acute appendicitis.

(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Bronchitis (Capillary)
(Duration) yrs. mos. 4 ds.

(Signed) J. O. Boyd M. D.
4/17 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. 4 days
Where was disease contracted if not at place of death? Acequia Idaho
Former or usual residence Acequia Idaho

19. PLACE OF BURIAL OR REMOVAL: Acequia Idaho
DATE OF BURIAL: 19

20. UNDERTAKER: E. L. Evett
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30281

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dora Weatherby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Mar 12 (Month) (Day) 1882 (Year)

7. AGE: 87 Yrs. 5 Mos. 5 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: E W King

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Margret Wallace

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. A. Weatherby

(Address) Twin Falls

15. Filed Apr 21 1920 John F. Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 17 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 21 1920 to April 17 1920 that I last saw her alive on April 17 1920 and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Empyema (purulent pleurisy)

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H W Wilson M. D.

April 17 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: 4-20 1920

20. UNDERTAKER: J E Dewitt

ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30282
Registered No.

1. PLACE OF DEATH
County of Jerome
City of (or Village) (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen C Hardy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May 1 (Month) (Day) 1842 (Year)

7. AGE: 78 Yrs. 11 Mos. 14 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tiffen Ohio

10. NAME OF FATHER: Jahan C Milly

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Ellen C Hardy

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Hardy
(Address) Twin Falls, Ida

15.
Filed Apr 16 1920
John F Caughlen
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1909 19 , to April 14 1920
that I last saw her alive on April 14 1920
and that death occurred on the date stated above, at 11:50 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis.

(Duration) 15 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. W. Wilson M. D.
April 16 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: William Burgahe
DATE OF BURIAL 19

20. UNDERTAKER: J E Wescott
ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 1085
File No. 30283

1. **PLACE OF DEATH**
County of Twin Falls
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Emma Shelly

Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** female
4. **COLOR OR RACE** white
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married (Write the word.)

6. **DATE OF BIRTH** aug 11 1886
(Month) (Day) (Year)

7. **AGE** 33 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work House wife
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Kan

10. **NAME OF FATHER** James Johnson

11. **BIRTHPLACE OF FATHER** (State or Country) Not Known

12. **MAIDEN NAME OF MOTHER** Mollie Smith

13. **BIRTHPLACE OF MOTHER** (State or Country) Not Known

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Eugene D Shelly
(Address) Twin Falls

15. Filed April 12 1920 John F Caughlan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** April 9 1920
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** April 2 1920, to April 9 1920
that I last saw h.er alive on April 9 1920,
and that death occurred on the date stated above, at 12 13 M.
The CAUSE OF DEATH* was as follows:
Purpura Hemorrhagica

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Streptococcus Sore Throat
(Duration) ..... Yrs. ..... mos. 5 ds.
(Signed) John F Caughlan M. D.
4-10 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Twin Falls Idaho — **DATE OF BURIAL** April 11 1920

20. **UNDERTAKER** J E Reed — **ADDRESS** Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 30284
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maria Meech

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July 6 (Month) (Day) 1872 (Year)

7. AGE: 47 Yrs. 7 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): France

10. NAME OF FATHER: Joseph V Iery

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Augustine Etienne

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F W Meech
(Address) 255 6 Ave N. T Falls, Ida.

15. Filed April 8 1920 John F Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 8 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1919, to April 8th 1920 that I last saw h.er alive on April 7 1920 and that death occurred on the date stated above, at 6:10 P.M.
The CAUSE OF DEATH* was as follows:
Cancer of ovary
Several
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John F Caughlin M. D.
4-8 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 4 10 1920

20. UNDERTAKER: L E Hurst — ADDRESS: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30285
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Shelley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: July (Month) 2 (Day) 1843 (Year)

7. AGE: 76 Yrs. 4 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Va

10. NAME OF FATHER: Nicholas Shelley

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mat Shuman

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J N Shelley
(Address): Rogerson

15.
Filed April 8 1920 John Landers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1920 to April 7 1920 that I last saw h... alive on April 7th 1920 and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Senility
(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Prostate
(Duration) yrs. mos. 16 ds.
(Signed) Duncan L Hayward M. D.
4/8 1920 (Address) Twin Falls Ida

*State the *Disease Causing Death*; or in deaths from *Violent Causes*, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah
DATE OF BURIAL: 4-8 1920

20. UNDERTAKER: J E Ward
ADDRESS: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30286
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lady Vilda Geary

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
6. DATE OF BIRTH: Dec 7 (Month) (Day) 1920 1919 (Year)
7. AGE: 1 Yrs. 9 Mos. ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Twin Falls Idaho
10. NAME OF FATHER: Rubes Geary
11. BIRTHPLACE OF FATHER (State or Country): Kansas
12. MAIDEN NAME OF MOTHER: Minnie Knight
13. BIRTHPLACE OF MOTHER (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) August Geary
(Address) Twin Falls, Ida.
15. Filed April 9 1920 John F. Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 7. (Month) (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from April 7 1920, to April 7 1920, that I last saw h.. alive on April 7 1920, and that death occurred on the date stated above, at 9 a M.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) Yrs. mos. 4 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. M. Leete M. D.
4/8 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 4-8 1920
20. UNDERTAKER: J. E. Dewitt — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 34

Primary Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30287

Registered No.

1. PLACE OF DEATH

County of

City of

(No. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vona Mann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White.	Married.

6. DATE OF BIRTH: June (Month) 13 (Day) 1886 (Year)

7. AGE: 33 Yrs. 9 Mos. 26 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: J.D. Bateman

11. BIRTHPLACE OF FATHER (State or Country): Texas.

12. MAIDEN NAME OF MOTHER: Bettie Jamison

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B M Mann

(Address) Buhl Idaho

15. Filed Apr. 7 1920

J. H. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 1st 1920, to Apr. 6 1920, that I last saw h.e.r alive on Apr 6 1920, and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Probably 2 (Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) George Jennings M. D.

4/6 1920 (Address) Buhl, Ida,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery	April 6 1920
20. UNDERTAKER	ADDRESS
Merrill & Rugg	Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 39

Primary Registration District No. 2087

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30288

Registered No. .....

1. PLACE OF DEATH

County of Twin Falls

City of Buhl

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilhelm Knigge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widdowed

6. DATE OF BIRTH: July (Month) 9 (Day) 1844 (Year)

7. AGE: 75 Yrs. 9 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Fred Knigge

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Sophie Bierman

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Knigge Jr.
(Address) Buhl Idaho

15. Filed Apr. 11 1920 — J. H. Murphy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 3 1920, to April 7 1920 that I last saw him alive on April 7 1920 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary): Asthenia.

(Duration) — yrs. — mos. 1 ds.

(Signed) F. A. Irmen M. D.

April 15 1920 (Address) Buhl Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clover Ida	4/11 1920

20. UNDERTAKER	ADDRESS
Homer B. Evans	Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

W. SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 34

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 2087
File No. 30289
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph J. Novacek.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: [illegible]

6. DATE OF BIRTH: July (Month) 3 (Day) 1903 (Year)

7. AGE: 16 Yrs. 9 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: Joseph Novacek

11. BIRTHPLACE OF FATHER (State or Country): Europe.

12. MAIDEN NAME OF MOTHER: Mary Poelish

13. BIRTHPLACE OF MOTHER (State or Country): Europe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles J. Novacek
(Address) Buhl Ida

15. Filed Apr. 12 1920 — J. H. Murphy, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch. 29, 1920 to April 11 1920 that I last saw h[illegible] alive on April 11 1920, and that death occurred on the date stated above, at 1[illegible] M.

The CAUSE OF DEATH* was as follows:

Typhoid Pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Marsh M. D.
4/12 1920 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: April 13 1920

20. UNDERTAKER: Merritt & Pugg — ADDRESS: Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 34

Primary Registration District No. 2087

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30296

Registered No. .....

1. PLACE OF DEATH

County of Twin Falls

City of Burl

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carsey Lloyd Ulrich.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: May (Month) 25 (Day) 1894 (Year)

7. AGE: 25 Yrs. 10 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: John H Ulrich

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Amanda Purdum

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John A Brown

(Address) .....

15. Filed Apr 19 1920

J. T. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-14-1920, to 4-14-1920, that I last saw him alive on 4-14-1920, and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Accidental - Explosion of Gas Lamp.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Jennings M. D.

4-15 1920 (Address) Burl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burl Cemetery — DATE OF BURIAL: Apr 19 1920

20. UNDERTAKER: Everitt & Riggs. — ADDRESS: Burl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 34

Primary Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30291

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of Buhl

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Whitelaw Reed Flynn.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: July (Month) 17 (Day) 1892 (Year)

7. AGE: 27 Yrs. 8 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Thos. Sherman Flynn

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Flora I. Brown

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Brown

(Address)

15. Filed Apr. 19 1920

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) – 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-14-1920, to 4-14-1920 that I last saw him alive on 4-14-1920 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Accidental – Explosion
Gas Lung.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. Jennings M. D.

4-15 1920 (Address) Buhl. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery	April 1920
20. UNDERTAKER	ADDRESS
Woodlee & Rigg	Buhl Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-35 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 39

Primary Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30292

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of Buhl

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna J Brem

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	(Write the word) Married

6. DATE OF BIRTH: May (Month) 4 (Day) 1891 (Year)

7. AGE: 28 Yrs. 11 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): No. Dakota

10. NAME OF FATHER: Joseph Kasolek

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Brem

(Address) Buhl, Idaho

15. Filed Apr 16 1920

J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-8- 1920, to 4-15- 1920, that I last saw her alive on 4-15- 1920, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Accidental - burns.

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Irving M. D.

4-16 1920 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery	April 16 1920
20. UNDERTAKER: Neuhs & Rugg	ADDRESS: Buhl Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 39

Registration District No. 39
Primary Registration District No. 2087

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30293
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burl
If death occurs away from usual residence, give facts called for under special information.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob Henry Skowalter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Widowed

6. DATE OF BIRTH December 22 18[illegible]
(Month) (Day) (Year)

7. AGE 67 Yrs. 4 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Jacob Skowalter.

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Mary Hollinsky.

13. BIRTHPLACE OF MOTHER (State or Country) Not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. G. Skowalter
(Address) Burl Ida.

15. Filed Apr 26 1920 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. 25 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-1-20 19..., to 4-25-20 19...,
that I last saw h[illegible] alive on 4-25-20 19...,
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Lower Jaw.

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Geo. Jennings M. D.
4-26 1920 (Address) Burl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Perie Kansas — DATE OF BURIAL 19...

20. UNDERTAKER [illegible] — ADDRESS Burl Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No.
File No. 30294
Registered No. 61

1. PLACE OF DEATH.
County of Valley
City of (No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lola May Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: f m
4. COLOR OR RACE: W N
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: January (Month) 20 (Day) 1898 (Year)

7. AGE: 22 yrs. 2 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clay Co Kansas

10. NAME OF FATHER: George Ross Avery

11. BIRTHPLACE OF FATHER (State or Country): Topeka Kansas

12. MAIDEN NAME OF MOTHER: Eva May Coz

13. BIRTHPLACE OF MOTHER (State or Country): Beloit Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): George Ross Avery
(Address): Donnelly Ida

15.
Filed ..... 191 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Apr (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1920 to Apr 2 1920 that I last saw her alive on Apr 1 1920 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia (Oedema)

(Duration) ..... yrs. ..... mos. 1/4 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 1/4 ds.

(Signed) G E Rogg M. D.
19 ..... (Address) Cascade Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Holmes Cemetary
DATE OF BURIAL: 4-4 1920
20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 56
Primary Registration District No. 1010.
(No. ..... St.)

File No. 30295
Registered No. 24

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Belle Lowery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Nov. (Month) 11 (Day) 1864 (Year)

7. AGE: 53 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Thos. Kerns

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Hannah Throp

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas H Lowery
(Address) Weiser Ida

15. Filed 3/18/20 19 ..... W R Hamelton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1920, to March 17th 1920 that I last saw h.r. alive on March 17th 1920, and that death occurred on the date stated above, at 7.P. M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis —

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Samuel Hamilton M. D.
3/18 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemtry | DATE OF BURIAL: 3-19 1920

20. UNDERTAKER: Northam & McCann | ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30296
Registered No. 25

1. PLACE OF DEATH
County of Washington Registration District No. 86
City of Weiser Primary Registration District No. 1010
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. P. Boadberry
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH
..... (Month) ..... (Day) 1[illegible] (Year)

7. AGE about
65 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Salesman · Curtis
(b) General nature of industry, business or establishment in which employed (or employer) Pub. Co.

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER Don't "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. C. Northam
(Address) Weiser Idaho

15. Filed Jan 1st 1920 W. P. Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from
..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Unknown. Apparently Stroke of Apoplexy died before Medical Assistance arrived
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. C. Northam Coroner
3/30 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Portland, Ore	..... 19.....
20. UNDERTAKER Northam & McCann	ADDRESS Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30297

Registered No. 26

1. PLACE OF DEATH

County of Washington

City of Weiser

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 28 (Day) 1861 (Year)

7. AGE: 58 Yrs. 7 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: William Parmenter

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Emeline Simms

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John E Smith

(Address) Weiser Ida

15. Filed 4/24 1920

W. R. Hamilton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 1st 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st 1920, to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Apoplexy Some heart lesion. Patient died before I reached her.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

4/23 1920, (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Helores Cemetery — DATE OF BURIAL: Apr 5 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 86
Primary Registration District No. 1010
(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30298
Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Washington
City of Weiser

2. FULL NAME Samuel Mathers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 2 (Day) 1837 (Year)

7. AGE: 83 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Samuel Mathers

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Jennie Grier

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D Mathers
(Address) Kimball Neb

15. Filed 4/5/20 19.....
N R Hamilton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3. 1919, to Apr. 1 1920.
that I last saw him alive on Apr. 1 1920.
and that death occurred on the date stated above, at 2.30 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Bladder
Urinary.

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Endocarditis
(Duration) 12 yrs. ..... mos. ..... ds.
(Signed) Lucas O Tinney M. D.
4/5 1920 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Strongharst Ill
DATE OF BURIAL ..... 19.....
20. UNDERTAKER: Northam & McCann
ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ~~4~~ 8 6 2112, File No. 30299

Primary Registration District No. ~~1005~~ 1010 Registered No. 28

1. **PLACE OF DEATH**

County of Washington

City of (No. ..... St.) (or) Not East of Payette

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Henry A Berry.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. **DATE OF BIRTH** Feb (Month) 8 (Day) 1832 (Year)

7. **AGE** 88 Yrs. — Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Iowa

10. **NAME OF FATHER** Wm Berry.

11. **BIRTHPLACE OF FATHER** (State or Country) Vermont

12. **MAIDEN NAME OF MOTHER** Not Known

13. **BIRTHPLACE OF MOTHER** (State or Country) Not Known

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs Bertha L. Healan
(Address) Curtis Nebraska

15. Filed 4/8/ 1926 W R Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Apr (Month) 6 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from (illegible) 1926 to (illegible) 1926 that I last saw h... alive on (illegible) 1926 and that death occurred on the date stated above, at 5 45 P. M.

The CAUSE OF DEATH* was as follows:

Lumbago

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Myocarditis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) W R Hamilton M. D.

4/7 1926 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Apr 11 1926

20. **UNDERTAKER** J H Adair ADDRESS Payette Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30300
Registered No. 29

1. PLACE OF DEATH
County of Washington
City (If outside limits of city or village, write the name of township.) 4 East of Payette No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8 6
Primary Registration District No. 1008 2112

2. FULL NAME Clarissa Berry,
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed 12

6. DATE OF BIRTH
Aug (Month) 25 (Day) 1839 (Year)

7. AGE
80 Yrs. 7 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wis

10. NAME OF FATHER Wildermuth

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Kline

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Bertha L. Heaton
(Address) Curtis Nebraska

15. Filed Apr 10 1920
4/10/20
J. [illegible]
Local Registrar
J. M. P. Kaulbach

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Apr (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4 1920 to Apr 4 1920
that I last saw h[illegible] alive on Apr 4 1920
and that death occurred on the date stated above, at 7 30 P. M.
The CAUSE OF DEATH* was as follows:
Influenza —
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. R. Woodward M. D.
4/7 1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Apr 11 1920
20. UNDERTAKER	**ADDRESS**
D. A. McClain	Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-21 M. 1-19.

CERTIFICATE O[illegible]

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6
Primary Registration District No. 212
File No. 30301
Registered No. 20

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. [illegible] St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Morton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Apr. (Month) 9 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 13 ds.
IF LESS than 1 day how many [illegible] hrs. or [illegible] min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Telford Morton

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Rosa Bowers

13. BIRTHPLACE OF MOTHER (State or Country): Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Telford Morton
(Address) Weiser Ida.

15. Filed 4/23/20 19[illegible] W R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1920, to Apr 22 1920 that I last saw her alive on Apr 22 1920 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Pamphegus Neonatorum
(Duration) [illegible] Yrs. [illegible] mos. 6 ds.
Contributory (Secondary) [illegible]
(Duration) [illegible] yrs. [illegible] mos. [illegible] ds.
(Signed) W. W. Robertson M. D.
4/23 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death [illegible] yrs. [illegible] mos. [illegible] days. In the State [illegible] yrs. [illegible] mos. [illegible] days
Where was disease contracted if not at place of death? [illegible]
Former or usual residence [illegible]

19. PLACE OF BURIAL OR REMOVAL: Fellcrest Cemetery — DATE OF BURIAL: 4/23 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser. Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No.
File No. 30302
Registered No.

1. PLACE OF DEATH.

County of Washington
City of Emmett (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Nancy Buchanan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. April. (Month) 9. (Day) 1920 (Year)

7. AGE: ....Yrs. ....Mos. 2 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mrs Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Emmett Idaho

10. NAME OF FATHER: Clarence A Buchanan

11. BIRTHPLACE OF FATHER (State or Country): N. D.

12. MAIDEN NAME OF MOTHER: Julia E Waller

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Julia E Buchanan
(Address) Emmett

15. Filed 5-10- 1920 Fatchmus Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April. (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April. 9. 1920, to April. 11- 1920, that I last saw him alive on April. 10 1920, and that death occured on the date stated above, at 6-a M.

The CAUSE OF DEATH* was as follows:
Premature.

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.

(Signed) Fatchmus M. D.
5-10 1920. (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett — DATE OF BURIAL: 5-12- 1920

20. UNDERTAKER: C R Parkinson — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 87

Primary Registration District No. .....

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30303

Registered No. .....

1. PLACE OF DEATH.

County of Washington

City of Midvale

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George L. Gallahan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.

November (Month) 12 (Day) 1855 (Year)

7. AGE

64 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Iowa

10. NAME OF FATHER: Andy Gallahan

11. BIRTHPLACE OF FATHER

(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER —

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bert C. Gallahan

(Address) Midvale Idaho

15.

Filed 5-10-1920

F. A. Schmidt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

April (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 26 1920, to April 29 1920, that I last saw him alive on April 28 1920, and that death occured on the date stated above, at 2 00 a M.

The CAUSE OF DEATH* was as follows:

Paralysis

.....(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. T. Sutton M. D.

5-8-1920 (Address) Midvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho

DATE OF BURIAL: April 30, 1920

20. UNDERTAKER: L R Fashmer

ADDRESS: Midvale Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 87

Primary Registration District No. .....

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30307

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Washington

City of Midvale

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Ristvet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: ....Yrs. ....Mos. 3 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Midvale Idaho

10. NAME OF FATHER J C Ristvet

11. BIRTHPLACE OF FATHER (State or Country) North Dakota

12. MAIDEN NAME OF MOTHER Ethel Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. O. Ristvet

(Address) Midvale

15. Filed 5-10-1920 F A Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1920, to Feb 7 1920, that I last saw him alive on Feb 6 1920, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Icterus Neonatorum

.....

.....

.....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) .....

.....(Duration ....yrs. ....mos. ....ds.

(Signed) W. F. Seeley M. D.

2/9 1920 (Address) Midvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale Ida — DATE OF BURIAL: Feb 8 1920

20. UNDERTAKER: A R Bashman — ADDRESS: Midvale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 210 F
File No. 90306
Registered No. 30316

1. PLACE OF DEATH
County of Bonner
City of Sandpoint (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clair Ivan Hagadone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: boy
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Dec. 24 (Month) 1919 (Year)

7. AGE: 1 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Culbertson, Mont.

10. NAME OF FATHER: George Hagadone

11. BIRTHPLACE OF FATHER (State or Country): Lexington, Neb.

12. MAIDEN NAME OF MOTHER: Lula Selepflue

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Hagadone
(Address) Sandpoint, Ida.

15. Filed May 8 1920 FLOYD G. WENDLE Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 21 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 29 1920, to Feb 21 1920
that I last saw him alive on Feb 21 1920
and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:
Influenza
..... (Duration) ..... Yrs. ..... mos. 13 ds.
Contributory (Secondary) Broncho Pneumonia
..... (Duration) ..... yrs. ..... mos. 7 ds.
(Signed) C. P. Stackhouse M. D.
3/23 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051 - 2051
(No. ..... St.)

File No. 30309
Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas J Joyce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 6 (Day) 1847 (Year)

7. AGE: 72 Yrs. 6 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Thomas Joyce

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizabeth Connor

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Sarah Joyce
(Address) Rathdrum Idaho

15. Filed 5/1 1920. Frank Wenger Local Registrar

SVMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1920, to Apr. 13 1920, that I last saw him alive on Apl 13 - 1920, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Uraemic Coma -

(Duration) ~ Yrs. 3 mos. ds.
Contributory (Secondary)
(Duration ~ yrs. ~ mos. ds.

(Signed) Earle V Brindle M. D.
4-14 1920 (Address) Spirit Lake Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Walnut Grove Cem Spokane — DATE OF BURIAL: April 15 1920

20. UNDERTAKER: A W. Letson — ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20
Primary Registration District No. 2011
(No. Providence Hospital St.)

File No. B 2370
Registered No. 14
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Steve Barbosa

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE
59 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Day Laborer.
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Austria

10. NAME OF FATHER Robert Barbosa

11. BIRTHPLACE OF FATHER (State or Country) Austria

12. MAIDEN NAME OF MOTHER Kate Grosla

13. BIRTHPLACE OF MOTHER (State or Country) Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mike Barbosa
(Address) Wallace Idaho

15.
Filed Mch 7 1920 F. L. Jungk
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Feby (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 24 1920, to Feby 28 1920
that I last saw h[illegible] alive on Feby 28 1920
and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Influenzal Pneumonia
8 (Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) James R Brown M. D.
3/7 1920 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	Mar. 3rd 1920

20. UNDERTAKER	ADDRESS
J. Harry Thompson	Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 38

Primary Registration District No. 7086

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30-311
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Walker

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. (Month) Jan (Day) 1 (Year) 851

7. AGE 69 Yrs. 3 Mos. 23 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) wife

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER James Bain

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Isobel Mc Knight

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Walker
(Address) Filer

15. Filed Apl. 25 ro 191.... A.A. Newberry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191.....
and that death occurred on the date stated above, at .....,.....M.
The CAUSE OF DEATH* was as follows:

Due to hemorrhage from
Cancer in side of neck

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory .....
(Secondary)

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) A.A. Newberry M. D.
.....19.... (Address) Registrar

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL I.O.O.F. DATE OF BURIAL Apr. 25... 1920.

20. UNDERTAKER F. E. Drake ADDRESS Filer

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 8
File No. 30312
Registered No. 57

1. PLACE OF DEATH

County of Ada
City of near Melba
(No. Ada Ten miles from Melba St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George E. Noble Jr.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 16 (Day) 1898 (Year)

7. AGE: 21 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cattle business

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa. Osage.

10. NAME OF FATHER: G. E. Noble

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Agnes Cronin

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Edgar Noble.

(Address) Boise Idaho.

15. Filed June 7 1920 L. P. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased from Was accidentally drowned in Snake River on May 29 1920 that I last saw ~~him~~ alive on May 28 1920, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Accidentally drowned.
Body recovered near Walter's Ferry
June 5 20

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Edgar Noble Brother. ~~M. D.~~ deceased.

19 ..... (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 6/7 1920

20. UNDERTAKER: Schreiber & Hedenstedt — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 30314
Registered No. 82

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Earner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	white	(Write the word.)

6. DATE OF BIRTH
June (Month) 5 (Day) 1920 (Year)

7. AGE
— Yrs. — Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER
John M. Earner

11. BIRTHPLACE OF FATHER
(State or Country) Illinois

12. MAIDEN NAME OF MOTHER
Lucy J. Eames

13. BIRTHPLACE OF MOTHER
(State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John M. Earner
(Address) Caldwell, Idaho

15.
Filed 6-11- 1920
John L. Meyer.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1920, to June 10 1920
that I last saw h. alive on June 10 1920,
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:
Hemorrhage from navel.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary):
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John L. Meyer M. D.
6-11-1920. (Address) Caldwell. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pleasant ridge	6-11 1920
20. UNDERTAKER	ADDRESS
C. F. Peckham	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30315
Registered No. 80

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Stella Harrington
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: July 15 1905 (Month) (Day) (Year)

7. AGE: 14 Yrs. 10 Mos. 24 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Fred M. Harrington

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary E. Krangueck

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred M Harrington
(Address) Caldwell, Ida.

15. Filed 6-11- 1920 John L Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 9 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1920, to June 9 1920, that I last saw her alive on June 9 1920, and that death occurred on the date stated above, at 5.30 A.M.

The CAUSE OF DEATH* was as follows:
Duration for pathfinder is probably a hemolytic Condition. No peritonitis or Nausea
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J M Reed M. D.
19 ... (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 6-13-1920
20. UNDERTAKER: [illegible] ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30516
Registered No. 79

1. PLACE OF DEATH
County of Owyhee
City of Homedale
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Norman Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 12 (Day) 1853 (Year)

7. AGE: 67 Yrs. — Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Henry Baker

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Sarah Baxter

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm J Frey
(Address) Eagle Ida

15. Filed June 6 1920 — Jos. A. Meyers — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1920, to June 4 1920
that I last saw him alive on June 4 1920
and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. / mos. 1 ds.
Contributory (Secondary) Appendicitis
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Simeon Hobbes M. D.
19..... (Address) Homedale

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL: June 8 1920

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Caldwell

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 1005

File No. 30317

Registered No. 78

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leona A. Waite

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: May (Month) 20 (Day) 1840 (Year)

7. AGE: 80 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Witter

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Clapp

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carrie C Gillette

(Address) .....

15. Filed June 3 1920 John S. Meyers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920, to June 2 1920

that I last saw h[illegible] alive on June 1 1920

and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J W Coon M. D.

6/2 1920 (Address) Caldwell Idaho

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal** or **Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: June 3 1920

20. UNDERTAKER: Case Turn Co.

ADDRESS: Cald.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30318
Registered No. 77

1. PLACE OF DEATH
County of Canyon
City of Notus
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lafayette Anderson Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH
Jan (Month) 2 (Day) 1827 (Year)

7. AGE
93 Yrs. 4 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Doctor
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Mississippi

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lee Swanner
(Address) Notus

15. Filed May 30 1920 John L. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Arterio Sc
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Old Age
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. M Cole M. D.
6-6 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ten Davis
DATE OF BURIAL: May 30 1920

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2005
File No. 30319
Registered No. 76

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esta Elsie Biehl.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ Widowed

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1884 (Year)

7. AGE: 35 Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Ralph Tightiser

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Emma Simons

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. E. Biehl
(Address) Nampa Ida

15. Filed 5-26- 1920 John S. Moyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 4 Dec. 1920, to May 23. 1920
that I last saw her alive on 5-23-1920
and that death occurred on the date stated above, at P M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos E. Mangum M. D.
5-24-1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 5-26-1920

20. UNDERTAKER: C. A. Beckham — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 30320
Registered No. 75

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Elizabeth Varner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~(Write the word)~~ widowed

6. DATE OF BIRTH: April 15 (Month) (Day) 1877 (Year)

7. AGE: 43 Yrs. 1 Mos. 8 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Augustus A. Cheverley

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Margaret Dennis

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Varner
(Address) Caldwell, Ida.

15. Filed 5-24-1920 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1920 to May 23 1920 that I last saw h[illegible] alive on May 23 1920, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Cox M. D.

5/24 1920 (Address) J. M. Cox

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 5-24-1920

20. UNDERTAKER: [illegible] — ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2005
File No. 30321
Registered No. 74

1. PLACE OF DEATH
County of Canyon
City of Wilder
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reuel Walter Moore
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 3 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER: W. H. Moore

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER: Grace Barrett

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 5-21- 1920 John D. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 19 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1920, to May 19 1920, that I last saw him alive on May 19 1920, and that death occurred on the date stated above, at 2.9 M.

The CAUSE OF DEATH* was as follows:
I Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. B. Black M. D.
May 19 1920 (Address) Wilder Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenleaf
DATE OF BURIAL: May 21 1920

20. UNDERTAKER: Case Funeral Co.
ADDRESS: Wilder

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30322
Registered No. 73

1. PLACE OF DEATH

County of Canyon
City of Caldwell (No. ..... St.)
Registration District No. 3
Primary Registration District No. 1021

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Emergene Covey Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Sept 17 1844 (Month) (Day) (Year)

7. AGE: 76 Yrs. 7 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Covey

11. BIRTHPLACE OF FATHER (State or Country): One of New England States

12. MAIDEN NAME OF MOTHER: Elisabeth Green

13. BIRTHPLACE OF MOTHER (State or Country): Rhode Island

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edith Kellis Brown
(Address) 1021 N 22nd Boise Idaho

15. Filed 5-19-1920 John P. Jones Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 17 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1920 to time of death that I last saw her alive on May 20 1920, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) not known as a dis

not seen (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Montgomery M. D.
5-19 1920 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death: ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? ( )

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] DATE OF BURIAL: 5-19-1920

20. UNDERTAKER: CASE FURNITURE CO. ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. Town
File No. 30323
Registered No. 72

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl Jane Cavin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 7 (Month) (Day) 1890 (Year)

7. AGE: 30 Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: David A. Shaw

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Serlina McKinley

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Velma Cavin
(Address) Baker, Oregon

15. Filed May 16 - 1920 John D. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1920, to May 16 1920
that I last saw h[illegible] alive on May 15 1920
and that death occurred on the date stated above, at 1.25 A.M.
The CAUSE OF DEATH* was as follows:
Ruptural appendix
Gunshot Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Farmer M. D.
5/16 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Baker City Ore. | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: [illegible] Sherman | ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

(13)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 30524
Registered No. 40

1. **PLACE OF DEATH**

County of Ada
City of Boise
(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Samuel C. Griffith

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: M

4. **COLOR OR RACE**: White.

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Widower

6. **DATE OF BIRTH**: Jan 24 (Month) (Day) 1841 (Year)

7. **AGE**: 79 Yrs. 3 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Ohio

10. **NAME OF FATHER**: Unknown

11. **BIRTHPLACE OF FATHER** (State or Country): Unknown

12. **MAIDEN NAME OF MOTHER**: Unknown

13. **BIRTHPLACE OF MOTHER** (State or Country): Unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) C. A. Bowen
(Address) 1303 Main St

15. Filed 5/3 1920 L. O. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: May 3 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to May 3 1920
that I last saw h~~im~~ alive on May 2 1920
and that death occurred on the date stated above, at 2A M.
The CAUSE OF DEATH* was as follows:

Cachexia Fever

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) Fred A. Tetzlaff M. D.
5/3 1920 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Brownell Kansas — **DATE OF BURIAL**: May 5 1920

20. **UNDERTAKER**: Summers & Steele — **ADDRESS**: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 30325
Registered No. 42

1. PLACE OF DEATH
County of Ada.
City of
(No. State Penitentiary St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Wick
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Unknown (Month) (Day) 1873 (Year)

7. AGE: 47 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. I. Cuddy
(Address) Boise Ida.

15. Filed May 6 1920 L. O. Gilman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1920, to May 4 1920
that I last saw him alive on May 3 1920
and that death occurred on the date stated above, at 2 9 M.
The CAUSE OF DEATH* was as follows:
Hemorrhage of brain
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Leo Galletta M. D.
5/6 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 6 1920
20. UNDERTAKER: Summers & Kreps — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Wylia Elmdist

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30320

Registered No. 43

1. PLACE OF DEATH

County of Ada

City of

(No. 1 Mile N W of Boise)

Registration District No. 8

Primary Registration District No. 2017

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucy M. Rogers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	married

6. DATE OF BIRTH: Feb. (Month) 17. (Day) 1858 (Year)

7. AGE: 62 Yrs. 2 Mos. 20 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Herrod Kinney

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Diantha Hollister.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. S. Rogers.
(Address) Boise Ida Rt 3.

15. Filed May 7 1920 L. P. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1920, to May 7 1920 that I last saw h[illegible] alive on May 2 — 1920 and that death occurred on the date stated above, at 1 9 M.
The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) James L Hunt M. D.

5/7 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	May 9 1920
20. UNDERTAKER	ADDRESS
Summers & Reed	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2054
(No. Ada County Hospital)

File No. 30327
Registered No. 44

1. PLACE OF DEATH
County of Ada
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Delano

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White.	Single

6. DATE OF BIRTH — — 1840
(Month) (Day) (Year)

7. AGE 80 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry T Kebs.
(Address) Boise Idaho.

15. Filed May 10 1920 L. P. Yeman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 6 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1919 to May 6 1920
that I last saw him alive on May 5 1920
and that death occurred on the date stated above, at 4.30 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis

(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Acute Myocarditis
(Duration) yrs. mos. 3 ds.

(Signed) T. N. Bradtan M. D.
May 7 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	May 8 1920
20. UNDERTAKER	ADDRESS
Summers & Gebs.	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2007
File No. 30328
Registered No. 71

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. U. P. N. P. Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theodore A. Daley.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single. (Write the word.)

6. DATE OF BIRTH: Mch. - 7 - 1891
(Month) (Day) (Year)

7. AGE: 29 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mineville, N.Y.

10. NAME OF FATHER: Chas. Daley.

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Ada Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Daley
(Address) Boise, Idaho.

15. Filed May 5 1920 L. O. Inman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May - 1 - 1920.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25, 1920 to May 1 - 1920
that I last saw him alive on May 1 - 1920
and that death occurred on the date stated above, at 3:30 P.M.,
The CAUSE OF DEATH* was as follows:
Tubercular Meningitis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. E. Crouch M. D.
5/3 1920 (Address) Boise, Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: 5/6 1920.

20. UNDERTAKER: W. McBratney.
ADDRESS: Boise Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 30329
Registered No. 45

1. PLACE OF DEATH
County of Ada.
City of So Boise.
(No. Beacon & Colorado St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel E. Fordyce
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: W (Widowed)

6. DATE OF BIRTH: Feb 24 1850 (Month) (Day) (Year)

7. AGE: 70 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business or establishment in which employed (or employer): ———

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Libbeus Fordyce

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Sarah J. Dearth.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. A. D. Fordyce
(Address) So Boise

15. Filed May 10 1920 L. O. Yeaman Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 15 1920, to May 6 1920 that I last saw him alive on May 5 1920, and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cerebral Hemorrhage
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) T. N. Bratton M. D.
May 7 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 11 1920
20. UNDERTAKER: Summers & Webb — ADDRESS: Boise Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 30330
Registered No. 42

1. PLACE OF DEATH

County of Ada

City of

(No. South Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emilie Krueger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 6 (Day) 1852 (Year)

7. AGE: 68 Yrs. 0 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Gustave Krueger

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. Krueger
(Address) R 5 Boise

15. Filed May 13 1920 L. O. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1920 to May 9 1920
that I last saw her alive on May 4 1920
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Rheumatic Deformans
and Heart Lesion
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John Bauch M. D.
May 12 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 13 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 52088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____

Primary Registration District No. 2744

File No. 30331

Registered No. 47

1. PLACE OF DEATH

County of Ada.

City of Boise

(No. South Third Grounds, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Ann Hood.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Jan (Month) 3. (Day) 1846 (Year)

7. AGE: 74 Yrs. 4 Mos. 11 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: George Amlong

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Sarah Hood.

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Weitman

(Address) Boise, Idaho.

15. Filed May 15 1920 L. P. Jumar
Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May. 13 - 1920.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920, to May 14 1920, that I last saw her alive on May 13 1920, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Neck, Groin & Foot

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) 1 yrs. 6 mos. ____ ds.

(Signed) DeWitt P. Higgs M. D.

5/14 1920. (Address) Boise Idaho.

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/16 1920

20. UNDERTAKER: W. M. Bratney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 30332
Registered No. 48

1. PLACE OF DEATH

County of Ada
City of West of Boise
(No. 4 M. West of Boise)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Alonzo Gardner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 16 (Day) 1863 (Year)

7. AGE: 57 Yrs. 0 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Richard Gardner

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. E. Gardner
(Address) Boise R 4

15. Filed May 17 1920 L. N. Inman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1920, to May 14 1920
that I last saw him alive on May 13 1920,
and that death occurred on the date stated above, at 6 9 M.
The CAUSE OF DEATH* was as follows:

General Septicemia

(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary) Streptococcic infection

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Tenney M. D.
May 17 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: May 15 1920
20. UNDERTAKER: Summers & Krebs
ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2015
File No. 30333
Registered No. 49

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 8 and Garden Ave St.) Bench

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Mary Lamb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	White	Single

6. DATE OF BIRTH. Feb 9th 1917 (Month) (Day) (Year)

7. AGE 2 Yrs. 6 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boise. Idaho

10. NAME OF FATHER John B. Lamb.

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Lauretta Clinton

13. BIRTHPLACE OF MOTHER (State or Country) Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John B. Lamb
(Address) Boise Ida

15. Filed May 24 1920 L. D. Green Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 23rd 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1920 to May 23 1920, that I last saw h alive on May 23 1920, and that death occured on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:

Tuberculosis Abscess

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Hunt Boork M. D.
5-24 1920 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	5/24 1920

20. UNDERTAKER	ADDRESS
Schmitz & Sidenfaden	Boise

Dr. Boork

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30334

Registered No. 50

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. Barracks St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert Harry Bode

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: March — 25 — 1920
(Month) (Day) (Year)

7. AGE: — Yrs. 2 Mos. — ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: Albert H. Bode

11. BIRTHPLACE OF FATHER (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Velma Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Bode
(Address) Boise Idaho.

15. Filed May 26 1920 L. P. Lemmon
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May — 25 — 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 25 1920 to May 25th 1926 that I last saw him alive on May 25th 1926, and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Mal-Nutrition

(Duration) — Yrs. 2 mos. — ds.

Contributory (Secondary) Spina Bifida

(Duration) — yrs. 2 mos. — ds.

(Signed) J. E. Church M. D.

5/25 1920. (Address) Boise Idaho.

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/26 1920

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 30335
Registered No. 51

1. PLACE OF DEATH
County of Ada
City of
If death occurs away from usual residence, give facts called for under special information.
(No. 5 Miles West of Boise St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Winfield Lowman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: January (Month) 7 (Day) 1912 (Year)

7. AGE: 7 Yrs. 11 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lowman Idaho

10. NAME OF FATHER: N. W. Lowman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Obie Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. W. Lowman
(Address) R 1 Boise

15. Filed May 26 1920 L. O. Thomas Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ saw
May 26 19 ... to ... 19 ...
that I last saw him alive on dead May 26 1920
and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Accidently drowned in Settlers Canal

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Clyde E. Summers Coroner
5/26 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: May 27 1920

20. UNDERTAKER: Summers & Trebs
ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30336

Registered No. 52

Registration District No. 8

Primary Registration District No. 2007

1. **PLACE OF DEATH**

County of Ada

City of Near Boise (No. 1 Mile West of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephen D. Vance

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M	White	Married

6. DATE OF BIRTH: Mar (Month) 2, (Day) 1859 (Year)

7. AGE: 61 Yrs. 3 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: J. T. Vance

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lulu E Vance
(Address) Boise, Idaho RD #2

15. Filed May 29 1920 L. O. Graves Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1920, to May 28 1920, that I last saw him alive on May 27 1920, and that death occurred on the date stated above, at 4.30 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Uraemic Poisoning

(Duration) yrs. mos. 4 ds.

(Signed) T. N. Bratton M. D.

May 29 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	May 30 1920
20. UNDERTAKER	ADDRESS
Summers & Kubo	Boise Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1104
File No. 30337
Registered No. 212

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marion Massa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: May (Month) 12 (Day) 1857 (Year)
7. AGE: 62 Yrs. 0 Mos. 19 ds.
IF LESS than 1 day how many..... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: James Massa
11. BIRTHPLACE OF FATHER (State or Country): Conn
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): Unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elena Massa
(Address) Boise Idaho.
15. Filed June 3 1920 L. O. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 14th 1920, to June 1st 1920
that I last saw him alive on June 1st 1920
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
(Duration) ..... Yrs. ..... mos. 16 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. 6 mos. ..... ds.
(Signed) J. E. Froom M. D.
6-3 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence 314 Thatcher St. Boise Ida.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: June 4 1920
20. UNDERTAKER: Summers & Kerby | ADDRESS: Boise Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30338
Registered No. 164

1. PLACE OF DEATH (37)

County of Ada
City of Boise
(No. 1312 Grove St.)
Registration District No. 2
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Doris Agnes Noble.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Fml	White	Single

6. DATE OF BIRTH. Feb. (Month) 4 (Day) 1920 (Year)

7. AGE ... Yrs. 2 Mos. 26 ds. IF LESS than 1 day how many ... hrs. or ... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Boise

10. NAME OF FATHER G E Noble

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Agnes Tuttle Cronin

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G E Noble
(Address) 1312 Grove St

15. Filed 5/1 1920 L. O. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr. (Month) 30th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 30 1920, to April 30 1920, that I last saw he alive on April 30 1920, and that death occured on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... Yrs. ... mos. 2 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) A. W. French M. D.

April 2 1920 (Address) Boise Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL St Johns Cemetery — DATE OF BURIAL 5/1 1920

20. UNDERTAKER Schreiber & Sidenfaden — ADDRESS

Dr. French.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30339
Registered No. 165

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Niederding

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH. June (Month) 4th (Day) 1853 (Year)
7. AGE: 66 Yrs. 10 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Draughtsman
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Prussia
10. NAME OF FATHER: not obtainable
11. BIRTHPLACE OF FATHER (State or Country): Prussia
12. MAIDEN NAME OF MOTHER: not obtainable
13. BIRTHPLACE OF MOTHER (State or Country): Prussia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs R. A. Diver
(Address) Stockton Calif.
15. Filed 5/1 1920
L. O. Inman Local Registrar
Spenceway

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 29th (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h.. alive on April 28 1920
and that death occured on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Paresis
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas V Greenway M. D.
19..... (Address) Overland Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery | DATE OF BURIAL: 5/2 1920
20. UNDERTAKER: Schreiber & Siebenfaden | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30340

Registered No. 166

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 112 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louie Wee Gang

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1869 (Year)

7. AGE: 51 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laundryman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) China

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) China

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lee Yow
(Address) Boise Ida

15. Filed 5/1 1920 L. P. Inman Local Registrar
Springer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April 29th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1920, to April 29 1920, that I last saw h[illegible] alive on April 29 1920, and that death occured on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:
Aortic Stenosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Springer M. D.

Apr 30 1920 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery — DATE OF BURIAL: 5/1 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24658

FORM [illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD of Health
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 2

County of Ada

Primary Registration District No. 1004

File No. 30341

City of Boise (No. 918 East Washington St.)

Registered No. 167

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Adelia Cooper

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Aug (Month) 7 (Day) 1853 (Year)

7. AGE: 66 Yrs. 8 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Jackson Co. N. C.

10. NAME OF FATHER: Samuel W. Gibson

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Mary Messer

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. A. Cooper

(Address) Blackfoot Ida

15. Filed May 1 1920 L. P. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Apr 30 1920, that I last saw h[illegible] alive on Apr 30 1920, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Mitral Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C H Kirkham M. D.

19.... (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Blackfoot Ida

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida — DATE OF BURIAL: 5/3 1920

20. UNDERTAKER: Schreiber & Fiedler Boise

ADDRESS

Parker

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25.M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30342

Registered No. 168

1. PLACE OF DEATH
County of Ada
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 401 - N. 19 - St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary C Rose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Dec - 21 - 1842
(Month) (Day) (Year)

7. AGE: 77 Yrs. 4 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Natchez Miss.

10. NAME OF FATHER: Christian Carl Druf

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise Idaho.

15. Filed 5/3 1920 L P Gilman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May - 2 - 1920
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 28 1920, to ~~Apr~~ May 2 1920
that I last saw her alive on May 1 1920,
and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Carcinoma Uteri.

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Pulmonary Oedema.
(Duration) yrs. mos. 4 ds.
(Signed) F. M. Braffan M. D.
5/3 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. ~~LENGTH~~ OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/3 1920

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Stewart

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30343
Registered No. 169

1. PLACE OF DEATH
County of Ada
City of Boise
(No. St. Lukes Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Wilson.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 4 (Day) 1897 (Year)

7. AGE: 22 Yrs. 9 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: S. E. Gould.

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Emma Kennedy.

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Scott Wilson
(Address) Caldwell

15. Filed May 4 1920 L. P. Permar Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 29 1920, to May 2 1920, that I last saw h..... alive on May 2 1920, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Post operative Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Pelvic Abscess & Salpingitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James L. Plumb M. D.

5/3 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Idaho. DATE OF BURIAL: May 5th 1920

20. UNDERTAKER: Summers & Hobbs. ADDRESS: Boise Ida.

FORM V. S. No. 5-25 M. 1-19.

Solomon.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

(No. St Lukes Hospital St.)

File No. 30344

Registered No. 170

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie S. Bixler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sep 15 (Month) (Day) 1881 (Year)

7. AGE: 39 Yrs. 7 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Willis Massey.

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Elma Bentley.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. R. Bixler

(Address)

15. Filed May 4 1920

L. P. Brinson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 2 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 30 1920, to May 2 1920, that I last saw h[er] alive on May 2 1920, and that death occurred on the date stated above, at 5 P.M.,

The CAUSE OF DEATH* was as follows:

complete suppression of urine following operation for cystic ovary.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. M. Robinson M. D.

May 4 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	May 9 1920
20. UNDERTAKER	ADDRESS
Summers & Webb.	Boise Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30345

Registered No. 171

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvina Ellen Garrett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Aug (Day) 12th (Year) 1858

7. AGE: 61 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Promise City, Iowa

10. NAME OF FATHER: Elias A. Park

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: Thomas.

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. F. Garrett

(Address) Boise

15. Filed May 6 1920 L. O. Jones Local Registrar

Dr. Stewart

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) May (Day) 3rd 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at 2, 4 P.M.

The CAUSE OF DEATH* was as follows:

Pyelonephritis + Suppurative Cystitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

5/4 1920 (Signed) James L. Stewart M. D.

(Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 4/5 1920

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., TYP. & BOOK. 24653

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics.

File No. 30347

Registered No. 174

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 411 Washington St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dwight Baum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. 5 (Month) 5 (Day) 1920 (Year)

7. AGE: Sunday — Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Born Idaho

10. NAME OF FATHER: W W Baum

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Laura McArthur

13. BIRTHPLACE OF MOTHER (State or Country): Denver Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W W Baum

(Address) Boise Idaho

15. Filed May 7 1920 L. O. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/5 1920, to 5/6 1920, that I last saw h-- alive on 5/6 1920, and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:

Congenital Heart Disease
(Fatty Fragmus Ovale) (Blue Baby)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fred A Fleming M. D.

5/8 1920 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 5/7 1920

20. UNDERTAKER: Schreiber & Siebenpfeiffer — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTGS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30348
Registered No. 175

1. PLACE OF DEATH
County of Ada
City of Boise. (No. 614 Front St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wong Tom Jung.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: China
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 7 1863 (Month) (Day) (Year)

7. AGE: 57 Yrs. — Mos. — ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laundryman
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): China.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): China.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas L Emory
(Address) ...

15. Filed May 8 1920 L. P. Sherman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 7 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920 to May 7 1920 that I last saw h-e alive on May 7 1920 and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Senility
... (Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) ...
... (Duration) ... yrs. ... mos. ... ds.
(Signed) Leo Allen M. D.
5/7 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Cheniss Cemetery. DATE OF BURIAL: May 8 1920.
20. UNDERTAKER: Summers & Keb. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30349

Registered No. 176

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 921 North 6th St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sidney Knight

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. January (Month) 14th (Day) 1846 (Year)

7. AGE: 74 Yrs. 3 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming & stock-raising

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Aynhoe, England

10. NAME OF FATHER: Henry Knight

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Knight

(Address) 921 N 6th St. Boise, Idaho

May 10 1920

L. O. Pyman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1918, to May 8th 1920, that I last saw him alive on May 8 1920, and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Paresis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Cerebral Apoplexy

(Duration) yrs. 5 mos. ds.

(Signed) Jos. R. Turner M. D.

5/9 1920 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/10 1920

20. UNDERTAKER: Schreiber & Siebenthaler — ADDRESS: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
very item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
d state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

BLANK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30350
Registered No. 179

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maurice Ennis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) (Day) 1858 (Year)

7. AGE: 62 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland.

10. NAME OF FATHER: Peter Ennis

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margt. Ennis

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Julia Ennis
(Address) Boise, Idaho.

15. Filed May 13 1920 L. P. Summers Local Registrar
Per Pettingill

SYMS - YORK CO., TYP. & BOOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1920, to May 10 1920, that I last saw h.. alive on May 1920, and that death occured on the date stated above, at 7. P. M.

The CAUSE OF DEATH* was as follows:

Solar Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Pettingill M. D.
5/11 1920 (Address) Eckalaqet Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Bayhorse Custer Co. Ida

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City, Utah — DATE OF BURIAL: 5/14 1920

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30351

Registered No. 180

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statem of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410 Hale St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver E. Tabor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 8 (Day) 1869 (Year)

7. AGE: 50 Yrs. 7 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: William Henry Tabor

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Emma Forbes

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Retta Boyle

(Address) Bruneau Idaho.

15. Filed May 13 1920

L. O. Pinman
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1920, to May 10 1920, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 12:30 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of face

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. O. Pinman M. D.

19.... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Bruneau Ida

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/14 1920

20. UNDERTAKER: Schreiber & Kiendorf — ADDRESS: Boise

Collister

FORM V. S. No. 5-25 M. 1-19.

Tormey.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30352
Registered No. 181

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Franklin Richardson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 26 (Month) (Day) 1909 (Year)

7. AGE: 11 Yrs. 0 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: J. E. Richardson

11. BIRTHPLACE OF FATHER (State or Country): Neo

12. MAIDEN NAME OF MOTHER: Alta B. Draper.

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alta B. Richardson
(Address) Payette Ida.

15. Filed May 13 1920 L. O. Truman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1920, to May 13 1920, that I last saw him alive on May 12 1920, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. Mooney M. D.

5/13 1920. (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Payette Ida

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho. DATE OF BURIAL: May 14 1920

20. UNDERTAKER: Summers & Keet ADDRESS: Boise Idaho.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30353
Registered No. 183

1. PLACE OF DEATH.

County of Ada
City of Boise
(No. 410 Hale St.)

Registration District No. 2
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept 11 1894 (Month) (Day) (Year)

7. AGE 25 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: Burkett

11. BIRTHPLACE OF FATHER (State or Country): Ala.

12. MAIDEN NAME OF MOTHER: Miss Newman

13. BIRTHPLACE OF MOTHER (State or Country): Ala.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Everett E Brown
(Address) Garden Valley Idaho

15. Filed May 14 1920 L. O. Pence Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1920, to May 13 1920, that I last saw her alive on May 13 1920, and that death occured on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. ds.
Contributory (Secondary) Influenza

(Duration) yrs. mos. 4 ds.

(Signed) Geo. R. Newman M. D.
19 (Address) Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence Roswell, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Roswell Idaho — DATE OF BURIAL: 5/14 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Female

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTGS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410, State St.)

Registration District No. 2

Primary Registration District No. 1004

File No. 30354

Registered No. 184

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Augustin Berrgoas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August (Month) 1 (Day) 1893 (Year)

7. AGE: 26 Yrs. 8 Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Sheepherder

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Francisco Selayo

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) Cristobal Arrasechea

15. Filed May 14. 1920 L. R. Inman Local Registrar

By Collister

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [illegible], 1920, to [illegible], 1920, that I last saw h[illegible] alive on [illegible], 1920, and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Intravenous of Vomica

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) Ivo Canada

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 5/15 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: (Boise)

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YORK CO., PRTS. & BOKS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30355

Registered No. 184½

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 Bale St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Henry Lupher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 8th (Day) 1878 (Year)

7. AGE: 41 Yrs. 6 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Farm

9. BIRTHPLACE (State or Country): Iowa Co. Iowa

10. NAME OF FATHER: David Lupher

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Badger

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. E Clark

(Address) La Feria Texas

15. Filed May 11 1920 L O Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1920, to May 16 1920, that I last saw h[im] alive on May 15 1920, and that death occured on the date stated above, at 5:12 9 M.

The CAUSE OF DEATH* was as follows:

Hill from Lunch and fractured Spinal Vertebra and Cord

(Duration) Yrs. mos. 21 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) A A Hyde M. D.

May 17 1920 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho. Cemetery — DATE OF BURIAL: May 18 1920

20. UNDERTAKER: Schreiber & Hollenbeck — ADDRESS: [redacted]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., SYS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004 1
File No. 30356
Registered No. 185

1. PLACE OF DEATH
County of Ada,
City of Boise
(No. 1302 N. 10th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lew Almond Wilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: June 15 — 1859
(Month) (Day) (Year)

7. AGE: 60 Yrs. 11 Mos. — ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Bible Worker.
(b) General nature of industry, business or establishment in which employed (or employer): & U.S. Surveyor

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Oscar F. Wilson,

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Marion J. Williams

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L. A. Wilson
(Address) Boise. Idaho,

15. Filed May 17 1920 L. V. Thomas
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May — 15 — 1920,
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 — 1920, to May 15 — 1920 that I last saw him alive on May 15 1920 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Uraemic poisoning

(Duration) ... Yrs. ... mos. 14 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) L. E. Broom M. D.
5/17 1920, (Address) Boise Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. ~~LENGTH~~ OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery. DATE OF BURIAL: 5/17 1920.

20. UNDERTAKER: W. McBratney ADDRESS: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30357

Registered No. 186

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH.

County of Ada

City of Boise (No. 1320 N. 5½ St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Denton Sloan Paul

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement should state CAUSE OF DEATH in plain terms, so that it may be properly classified. PHYSICIANS of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 21st 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Boise: Idaho

10. NAME OF FATHER: Denton Z. Paul

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Refugio Sloan

13. BIRTHPLACE OF MOTHER (State or Country): Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Denton S. Paul

(Address) Boise Ida

15. Filed May 17 1920 L. O. Numan Local Registrar

Numbers

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1920, to May 16 1920, that I last saw him alive on May 16th 1920, and that death occured on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Ingestion of Spider bite

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary): Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno R. Numan M. D.

19 ..... (Address) Boise,

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	5/17 1920
20. UNDERTAKER	ADDRESS
Scheibel & Sidenfaden	Boise

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1324 W Jefferson st.)

File No. 30358

Registered No. 187

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** John Kirby White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. **DATE OF BIRTH** June 23 1879
(Month) (Day) (Year)

7. **AGE** 40 Yrs. 10 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Commissioner of Public
(b) General nature of industry, business or establishment in which employed (or employer): Welfare Dept of Idaho

9. **BIRTHPLACE** (State or Country) Indiana

10. **NAME OF FATHER** Harve White

11. **BIRTHPLACE OF FATHER** (State or Country) Indiana

12. **MAIDEN NAME OF MOTHER** Susie Southerland

13. **BIRTHPLACE OF MOTHER** (State or Country) Indiana

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) C. W. White
(Address) U. S. S. Chaseey Sandiego

15. Filed May 17 1920 L. D. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** 5 16 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1920, to 5/13 1920 that I last saw him alive on 5/13 1920, and that death occurred on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Tuberculosis of Kidney & Bladder

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ralph Todd M. D.

5/17 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Morris Hill — **DATE OF BURIAL** May 17 1920

20. **UNDERTAKER** Summers & Peck — **ADDRESS** Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30359

Registered No. 188

1. **PLACE OF DEATH**

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. St Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs C. T. Snow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH — — 1870
(Month) (Day) (Year)

7. AGE 50 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housekpr.
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry T Webb
(Address) Boise Idaho.

15. Filed May 17 1920 L V Bonnar Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 16 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 26 1920, to May 16th 1920
that I last saw her alive on May 16 1920
and that death occurred on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:
Gall stones complicated

(Duration) — Yrs. 10 mos. — ds.
Contributory (Secondary) Surgical operation

(Duration) — yrs. — mos. — ds.

(Signed) L. E. Broom M. D.
5-17 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho.	May 17 1920
20. UNDERTAKER	ADDRESS
Summers & Webb	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Ada

City of Boise

(No. 1816 N. 15th St.)

Registration District No. 2

Primary Registration District No. 1004

File No. 30360

Registered No. 1891

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara A Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 1 (Day) 1879 (Year)

7. AGE: 41 Yrs. 4 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Geo K Anderson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Clara West

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. G. Miller

(Address)

15. Filed May 23 19 20 L. V. Sherman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1920, to May 18 1920 that I last saw her alive on May 18 1920, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D P Higgs M. D.

5-20 1920 (Address) 16th Wash & Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 23 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho.
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30361
Registered No. 190

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 209 Locust St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe M. Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Jan (Month) 14th (Day) 1860 (Year)

7. AGE: 60 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rochester N. Y.

10. NAME OF FATHER: Augustus Burnell

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Katherine White

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. C. Burnell
(Address) Boise

15. Filed May 21 1920 L. O. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 11 1920 to May 20th 1920 that I last saw h.. alive on May 20th 1920 and that death occured on the date stated above, at 10 10 A.M.

The CAUSE OF DEATH* was as follows:
Diabetis mellitis

(Duration) 10 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Roscoe C. Ward M. D.
5/21 1920 (Address) Overland & Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 5/22 1920

20. UNDERTAKER: Schneider & Siebenfaden — ADDRESS: Boise

N. B.—Every information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., MFG. & STNRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus St.)

File No. 30362
Registered No. 191

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Yee Bee We

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Yellow
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) (Year): 1856

7. AGE: about 64 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wong Lee
(Address)

15. Filed May 21 1920 L. P. Quinn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1920, to May 19 1920, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:
Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo Cellers M. D.
..... 19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence: Boise Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chinese Cemetery	5/22 1920

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise

Dr. Collister

SYMS - YORK CO., TYPES. & BOOKS. 24858

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30363
Registered No. 192

1. **PLACE OF DEATH**

County of Ada

City of Boise.

(No. 320 Broad St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** William M. Samuelsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W	Single

6. **DATE OF BIRTH** Jan (Month) 29 (Day) 1897. (Year)

7. **AGE** 23 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Cook.

(b) General nature of industry, business or establishment in which employed (or employer): ——

9. **BIRTHPLACE** (State or Country) Utah.

10. **NAME OF FATHER** Thomas F Samuelsen

11. **BIRTHPLACE OF FATHER** (State or Country) Denmark.

12. **MAIDEN NAME OF MOTHER** Sarah Reeves.

13. **BIRTHPLACE OF MOTHER** (State or Country) Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) T. F. Samuelsen

(Address) Boise Idaho

15. Filed May 21 1920 C. A. Thomas Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** May (Month) 19 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** May 9 1920, to May 19 1920 **that I last saw h.im alive on** May 18 1920, **and that death occurred on the date stated above, at** 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis.

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Exhaustion & Toxaemia

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) T. N. Brayton M. D.

May 20 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	May 21 1920.

20. UNDERTAKER	ADDRESS
Summers & Kibbe.	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30364

Registered No. 193

1. PLACE OF DEATH.

County of Ada

City of Boise

(No. 410, State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Royce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 10 (Day) 1868 (Year)

7. AGE: 51 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Photographer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oaklakam Eng.

10. NAME OF FATHER: George or Sep. Royce

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah ?

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) George Meier

(Address) Boise Idaho

15. Filed May 24 1920 L. P. Gunn Local Registrar

Pilling

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1920, to May 23 1920, that I last saw h[illegible] alive on May 23 1920, and that death occured on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Arsenic poisoning from accumulation of Medicament.

(Duration) 1 Yrs. 1 mos. ds.

Contributory (Secondary): Syphilis

(Duration) yrs. mos. ds.

(Signed) Fred A Pettingill M. D.

5/24 1920 (Address) Overland Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 5/24 1920

20. UNDERTAKER: Schreiber & Anderson — ADDRESS: Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30365

Registered No. 194

1. **PLACE OF DEATH**

County of Ada.

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1604 Washington St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** John Redvers Kent

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. **DATE OF BIRTH** Apr. 16 — 1902
(Month) (Day) (Year)

7. **AGE** 18 Yrs. 1 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: In school.

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) England

10. **NAME OF FATHER** John Kent

11. **BIRTHPLACE OF FATHER** (State or Country) England

12. **MAIDEN NAME OF MOTHER** Ellen Oliver

13. **BIRTHPLACE OF MOTHER** (State or Country) England.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) W. McBratney

(Address) Boise Idaho.

15. Filed May 25 1920 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** May — 22 — 1920
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 6 1920 to May 22 1920, that I last saw h.. alive on May 22 1920 and that death occurred on the date stated above, at 11.30 M.

The CAUSE OF DEATH* was as follows:

Endocarditis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. S. Springer M. D.

5/24 1920 (Address) Boise, Idaho

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Morris Hill Cemetery — **DATE OF BURIAL** 5-25-1920

20. **UNDERTAKER** W. McBratney — **ADDRESS** Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Ada

City of Boise (No. 510 N 12 St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

File No. 30366

Registered No. 195

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** John W Shields

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: M

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: Nov. (Month) 6 (Day) 1872 (Year)

7. **AGE**: 47 Yrs. 6 Mos. 16 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Ohio

10. **NAME OF FATHER**: James W Shields

11. **BIRTHPLACE OF FATHER** (State or Country): Ohio

12. **MAIDEN NAME OF MOTHER**: Mary Gilland

13. **BIRTHPLACE OF MOTHER** (State or Country): Ohio

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs James W Shields

(Address) 510 N 12 st Boise Ida

15. Filed May 25 1920 L. P. Skinner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: May (Month) 22 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Apr 17 1920, to May 22 1920 that I last saw h.im alive on May 22 1920 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Pleurisy Bronchopneumonia

(Duration) yrs. 1 mos. 3 ds.

(Signed) F. N. Barton M. D.

May 24 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Morris Hill Cemetery | **DATE OF BURIAL**: May 25 1920

20. **UNDERTAKER**: Summers & Krebs | **ADDRESS**: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30367
Registered No. 196
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 2
Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.
(No. 1205, No. 8 St., St.)

2. FULL NAME Annas Powell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Widow (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 6 (Day) 1836 (Year)

7. AGE 83 Yrs. 6 Mos. 18 ds.

IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wales

10. NAME OF FATHER Morris, Evan

11. BIRTHPLACE OF FATHER Wales (State or Country)

12. MAIDEN NAME OF MOTHER Mary Nicholas

13. BIRTHPLACE OF MOTHER Wales (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. David Williams

(Address) Boise Idaho

15. Filed May 25 1920 L. P. Skinner Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1920 to May 24 1920 that I last saw her alive on May 24 1920 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary) Cardiac

(Duration) Yrs. mos. ds.

(Signed) P. S. Gregory M. D.

5/25 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days, In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery. DATE OF BURIAL May 25 1920.

20. UNDERTAKER Summers & Krebs ADDRESS Boise Idaho.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30368

Registered No. 197

1. PLACE OF DEATH.

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 410 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. May (Month) 24 (Day) 1920 (Year)

7. AGE ....Yrs....Mos....ds.

IF LESS than 1 day how many 4 hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... none

(b) General nature of industry, business, or establishment in which employed (or employer)....

9. BIRTHPLACE (State or Country) Boise Ida

10. NAME OF FATHER Clarence J. Jones

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Mary Peart

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clarence J. Jones

(Address) 410 Home Ida

15.

Filed May 26 1920

L. P. Quinn
Local Registrar

Pittsburgh

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/24 1920, to 5/24 1920, that I last saw him alive on 5/24 1920, and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia 7½ Mo

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) ....

....(Duration ....yrs. ....mo. ....ds.

(Signed) Fred A. Williams M. D.

5/26 1920 (Address) Cleland Bldg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery

DATE OF BURIAL 5/26 1920

20. UNDERTAKER Schreiber & Sidenstein

ADDRESS Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PRTS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30369

Registered No. 198

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada

City of Boise, Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1019 Grove St.)

2. FULL NAME Frank Rayle Coffin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August 4th 1838 (Month) (Day) (Year)

7. AGE: 81 Yrs. 9 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Banker
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Near Annapolis, Indiana

10. NAME OF FATHER: Thomas Chalkley Coffin

11. BIRTHPLACE OF FATHER (State or Country): New Garden N.C.

12. MAIDEN NAME OF MOTHER: Mary Haney

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary F. Coffin
(Address) 1019 Grove St. Boise, Idaho.

15. Filed May 27 1920 L. P. Inman Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1st 1920, to May 25 1920, that I last saw h.i.m. alive on May 25 1920, and that death occured on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:
Acute Hemorrhagic Gastritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cirrhosis of Liver, Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Smith M. D.

5/26/1920 (Address) Boise, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 5/27 1920

20. UNDERTAKER: Schreiber & Heidenfelden — ADDRESS: Boise

Dr Smith

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30370
Registered No. 199

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Charters

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Dec (Month) 29 (Day) 1880 (Year)
7. AGE: 39 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country) Edina, Mo.
10. NAME OF FATHER Peter Carey.
11. BIRTHPLACE OF FATHER (State or Country) Iowa
12. MAIDEN NAME OF MOTHER Johanna Murphy
13. BIRTHPLACE OF MOTHER (State or Country) Cork, Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant)
(Address)
15. Filed May 27 1920 R. O. Inman Local Registrar

SYMS - YORK CO., PRES. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1920, to May 26 1920, that I last saw h[illegible] alive on May 26 191, and that death occured on the date stated above, at 5 A. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) Years Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) L. P. McCalla M. D.
5/24 1920 (Address) Boise Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the St. Alphonsus Hospital State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Eagle Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 5/28 1920
20. UNDERTAKER: Schreiber & Sedenquist — ADDRESS: (Boise)

L. P. McCalla

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30371

Registration District No. 2
Primary Registration District No. 1004
Registered No. 200

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Kolanowski

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. 16 1910 (Month) (Day) (Year)

7. AGE: 9 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Chicago Ill

10. NAME OF FATHER: Vincent Kolanowski

11. BIRTHPLACE OF FATHER (State or Country): Poland

12. MAIDEN NAME OF MOTHER: Mary Czarachowicz

13. BIRTHPLACE OF MOTHER (State or Country): Chicago Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Kolanowski
(Address) Boise Ida.

15. Filed May 27 1920 L. P. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 27th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1920, to May 27 1920, that I last saw h... alive on May 26 1920, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Organic heart disease of Mitral & Aortic Valves
(Duration) Yrs. 5 mos. ds.
Contributory (Secondary) Pneumonia Influenza 1919
(Duration) yrs. mos. 16 ds.

(Signed) D. C. Higgs M. D.
5-27 1920 (Address) 622 Reach St Boise

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 14 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery DATE OF BURIAL: 5/27/1920

20. UNDERTAKER: Schreiber & Sidney Feden ADDRESS: Boise
or Hicks

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO. PTRS. & SONS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30372
Registered No. 201

1. PLACE OF DEATH.
County of Ada
City of Boise
(No. 633 Ash St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matilda Woods

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. May 15th 1850 (Month) (Day) (Year)
7. AGE: 70 Yrs. — Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: Jos. White
11. BIRTHPLACE OF FATHER (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: E. Larimar
13. BIRTHPLACE OF MOTHER (State or Country): Ohio
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J. J Churchill
(Address) Boise Idaho
15. Filed May 28 1920 L. O. Anna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27th (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3/13 1920, to 5/26 1920, that I last saw her alive on 5/26 1920, and that death occured on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Carcinoma of the Lung.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Carcinoma of Breast removed 3 years ago
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Fred A Kittinger M. D.
5/28 1920 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence Clarinda Iowa.

19. PLACE OF BURIAL OR REMOVAL: Clarinda Iowa — DATE OF BURIAL: 5/28 1920
20. UNDERTAKER: Schriber & Siebengaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24858

Dr. Pittenger

Tuberculosis.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30373

Registered No. 202

1. **PLACE OF DEATH**

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1004

(No. 116 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nina Maude Vandeford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH: Oct (Month) 17 (Day) 1895 (Year)

7. AGE: 24 Yrs. 7 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Work
(b) General nature of industry, business or establishment in which employed (or employer): at Home

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: J. N. Vandeford

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Jane Vanhorn

13. BIRTHPLACE OF MOTHER (State or Country): Del.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jess Vandeford
(Address) Boise

15. Filed May 29 1920 L. A. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1919 to May 27 1920 that I last saw her alive on May 28 1920 and that death occurred on the date stated above, at 6A M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(Duration) Yrs. 1 mos. 15 ds.

Contributory (Secondary): Pulmonary tuberculosis

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) M. H. Dalerman M. D.

5/29 1920. (Address) Boise Ida

*State the *Disease Causing Death*; or in deaths from **Violent Causes**, state (1) Means of Injury; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 30 1920

20. UNDERTAKER: Summers & Turk — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Collisted

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3054

Registered No. 203

1. **PLACE OF DEATH**

County of Ada

City of Boise

(No. 1001 W. State St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Phineas Haley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: April (Month) 24 (Day) 1853 (Year)

7. AGE: 67 Yrs. 1 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Benjamin Haley

11. BIRTHPLACE OF FATHER (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jessie M. Haley

(Address) 1001 W. State Boise Ida.

15. Filed May 29 1920 L. P. Jones Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 2 1920, to May 28 1920, that I last saw h-- alive on May 28 1920, and that death occurred on the date stated above, at 12 25 M.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Calvert M. D.

5/29 1920. (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: May 30 1920

20. UNDERTAKER: Summers & Freds — ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2007
(No. ....., ... St.)

File No. 30375
Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Canyon
City of Parma

2. FULL NAME mildred m Bowden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH.
Nov (Month) 11 (Day) 1871 (Year)

7. AGE
48 Yrs. 6 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)... None

9. BIRTHPLACE
(State or Country) Iowa

10. NAME OF FATHER: Samuel Bowen

11. BIRTHPLACE OF FATHER
(State or Country) Indiana

12. MAIDEN NAME OF MOTHER: Amanda Carr

13. BIRTHPLACE OF MOTHER
(State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edna Bowden
(Address) Parma Ida

15.
Filed May 31 1920 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1920, to May 28 1920 that I last saw h-y alive on May 28 1920 and that death occured on the date stated above, at 6-9 M.

The CAUSE OF DEATH* was as follows:
Cancerous Affection of pelvic cavity

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) —
(Duration — yrs. — mos. — ds.

(Signed) W. L. Waldrop M. D.
May 29 1920 (Address) Parma, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma Ida — DATE OF BURIAL: May 31, 1920

20. UNDERTAKER: Beckham Fun Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30376

Registered No. 8

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 3

Primary Registration District No. 2087

County of Canyon

City of Apple Valley precinct (If outside limits of city or village, write RURAL.) ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ..... Dooms

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. May (Month) 13 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds. 2 hrs. IF LESS than 1 day how many 2 hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo. A. Dooms

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Ida Smallwood

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Dooms
(Address) Parma R. 2.

15.
Filed ..... 191.....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1920, to May 13 1920, that I last saw her alive on May 13 1920, and that death occured on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:
Premature birth (6 mos ?)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.

5/14 1920 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Apple Valley — DATE OF BURIAL: May 13 1920

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30377
Registered No. 7

Registration District No. 5
Primary Registration District No. 2009

1. PLACE OF DEATH
County of Payette
City of New Plymouth (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Forrest R Wilfong
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 9 (Day) 1903 (Year)

7. AGE: 16 Yrs. 9 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Hugh Wilfong

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Ruthal Berkley

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X [illegible]
(Address) [illegible]

15. Filed 5-24 1920 Wm T. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1920, to May 21 1920, that I last saw h[illegible] alive on May 21 1920, and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Diabetes
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Furuncles Pneumonia
(Duration) yrs. mos. 10 ds.
(Signed) Wm T Drysdale M. D.
5-24 1920 (Address) New Plymouth Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth — DATE OF BURIAL: 5-24-1920

20. UNDERTAKER: J W Adair Payette — ADDRESS: Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 1009
File No. 30378
Registered No. 6

1. PLACE OF DEATH.
County of Payette
City of New Plymouth
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles A. Strong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 20 (Day) 1858 (Year)

7. AGE: 61 Yrs. 7 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Orchardist
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Orren R. Strong

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Amanda Gibbs

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Russel Strong
(Address) Moscow

15. Filed ..... 191.... Wm T. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1918, to April 26 1920, that I last saw h. in alive on April 26 1920, and that death occured on the date stated above, at 9:20 A. M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) 40 minutes Yrs. mos. ds.
Contributory (Secondary): Asteria Sclerosis
(Duration several yrs. mos. ds.

(Signed) Wm T Drysdale M. D.
4-28 1920 (Address) New Plymouth Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Ida
DATE OF BURIAL: 4-28- 1920

20. UNDERTAKER: A. Meyer
ADDRESS: New Plymouth

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30379

Registered No.

Registration District No. 1018

Primary Registration District No.

1. PLACE OF DEATH

County of Gem

City of [redacted] Street (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME no name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: 4 (Month) - 14 (Day) 1920 (Year)

7. AGE: ....Yrs....Mos....ds.

IF LESS than 1 day how many 3 hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Sweet Ida.

10. NAME OF FATHER: Roy E. Mayhew

11. BIRTHPLACE OF FATHER (State or Country): Kans.

12. MAIDEN NAME OF MOTHER: Tella M Mervin

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Burton O Clark M D

(Address) Emmett Ida

15. Filed 5/14 1920 J. W. Thompson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 4 (Month) - 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-14 1920, to 4-14- 1920 that I last saw h[redacted] alive on 4-14 - 1920 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Immature

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) Premature built-

....(Duration) ....yrs. ....mos. ....ds.

(Signed) Burton O Clark M. D.

4-13-1920 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ....19....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Gem

City of Emmett

Registration District No. 10 W

Primary Registration District No. ....

(No. ...., ... St.)

File No. 30380

Registered No. ....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME first name

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	

6. DATE OF BIRTH

4 (Month) — 28 (Day) — 1920 (Year)

7. AGE

.... Yrs. .... Mos. .... ds.

IF LESS than 1 day how many 3 hrs. or .... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Emmett Ida.

10. NAME OF FATHER William E. Pratt

11. BIRTHPLACE OF FATHER (State or Country) ....

12. MAIDEN NAME OF MOTHER Myra A Swainson

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Burton O Clark

(Address) Emmett

15.

Filed K/29 1920

J L Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

4 (Month) — 28 (Day) — 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-25- 1920, to 4-28- 1920 that I last saw him alive on 4-28 1920, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows: —

Pneumonia

.... (Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary) Premature fetus

.... (Duration) .... yrs. .... mos. .... ds.

(Signed) Burton O Clark M. D.

.... 19.... (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days

Where was disease contracted if not at place of death? ....

Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL .... 19....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30381

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1000
(No. , St.)
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Warren Twilegar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: Mar 12 1916 (Month) (Day) (Year)

7. AGE: 4 yrs. 1 mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Child
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: G. E. Twilegar

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Dolcenia Scott

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): G. E. Twilegar
(Address): Emmett Idaho

15. Filed 5/2 1920 J. M. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr 28 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, that I attended deceased from ..... 191..., to ..... 191...
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental drowning

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. M. Brown Coroner M. D.
4/29 1920 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: Apr 30 1920

20. UNDERTAKER: C. D. Brockman
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 10 2d
County of Gem Primary Registration District No.
City of Emmett (No. ..., ... St.) File No. 30382
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William D. Wayman

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 4 (Day) 1844 (Year)

7. AGE: 76 yrs. 2 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Guthrie
(Address) Emmett Idaho

15.
Filed May 12 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191...
that I last saw h... alive on ... 191...,
and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:
Probably Chronic Myocarditis
(Duration) Several yrs. mos. ds.
Contributory (Secondary) Chronic Nephritis
(Duration) ? yrs. mos. ds.

(Signed) R. N. Cummings M. D.
May 17 1920 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 5/12 1920

20. UNDERTAKER: C. E. Buckmun
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 102
Primary Registration District No.
(No. ..., ... St.)

File No. 30383
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Blanche Wallis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 11 (Day) 1897 (Year)

7. AGE: 22 yrs. 9 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: L. L. Cantrell

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Mary Hackett

13. BIRTHPLACE OF MOTHER (State or Country): Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis Wallis
(Address) Emmett Idaho

15.
Filed May 12 1920 — J. C. Reynolds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Febr 2 1920, to March 1920, that I last saw her alive on May 7 & 8 1920, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ... yrs. 3½ mos. — ds.

Contributory (Secondary): Influenza

(Duration) ... yrs. ... mos. 10 ds.

(Signed) R N Cummings M. D.

May 10 1920 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Alpha Idaho
DATE OF BURIAL: May 12 1920

20. UNDERTAKER: O D Bucknum
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30384
Registered No.

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1010
Primary Registration District No.
(No. ..., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Eunice Patton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married

6. DATE OF BIRTH: Nov 23 1884 (Month) (Day) (Year)

7. AGE: 35 yrs. 4 mos. 25 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: A. J. Sullivan

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary E. Reynolds

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Sullivan
(Address) Emmett Ida

15.
Filed May 11 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 18 1920, to April 18 1920, that I last saw her alive on April 18 1920, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Strychnine Poisoning
(Suicidal)

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Austin D. Boyd M. D.
April 20 1920 (Address) Emmett Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 4/20 1920

20. UNDERTAKER: C. D. Buckner
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Canyon

City of .....

Registration District No. 7

Primary Registration District No. 2006

(No. ....., ... St.)

File No. 30385

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Nelson McDonald

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 1 (Day) 1 (Year)

7. AGE: 63 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER David L McDonald

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Martha Hunter

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G H Saunders

(Address) Houston Ida

15.

Filed May 27 1920 Pearle Dodds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Apr (Month) 15th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 30th 1920, to 4-15 1920, that I last saw h— alive on Apr-14 1920 and that death occured on the date stated above, at 4A M.

The CAUSE OF DEATH* was as follows:

Apoplexy

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Thos R Mangum M. D.

5-26 1920 (Address) Nampa Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: Apr 17 1920

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2004
File No. 30386
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William S Wade

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 4 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Moscow Idaho

10. NAME OF FATHER: Edward S Wade

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Dora Bogue
(Address) Nampa Idaho

15. Filed June 16 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1920, to June 2 1920, that I last saw him alive on June 2 1920, and that death occured on the date stated above, at 3.15 P M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Pharyngeal of Larynx of the Oesophagus
(Duration) Unknown Yrs. ..... mos. ..... ds.
Contributory (Secondary) Ulcers of the Oesophagus
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) D O'Bogue M. D.
19..... (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 3 mos. 27 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Moscow Idaho
Former or usual residence Moscow Idaho

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 6-4 1920

20. UNDERTAKER: F. K. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30387

Registered No. .....

Registration District No. 7

Primary Registration District No. 2006

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Milligan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 10 (Day) 1 (Year)

7. AGE: 9 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thos. Milligan

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Lea Roth

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos Milligan

(Address) Nampa Ida

15.

Filed June 10 1920. Pearle Dodds Local Registrar

E Chilton

SYMS - YORK CO., PTHS. [illegible]

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5th 1920, to June 8 1920, that I last saw her alive on June 8 1920, and that death occured on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia,

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Malaria

(Duration ..... yrs. ..... mos. 7 ds.

(Signed) Leo N. Chilton M. D.

19..... (Address) Nampa, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlenberger Cem. | DATE OF BURIAL: 6 9 1920

20. UNDERTAKER: F. N. Robinson | ADDRESS: Nampa

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 30388
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. 618 9th Ave S St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josea B Swain

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)
7. AGE: 72 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Mich
10. NAME OF FATHER Abram Swain
11. BIRTHPLACE OF FATHER (State or Country) N York
12. MAIDEN NAME OF MOTHER Betsy Barber
13. BIRTHPLACE OF MOTHER (State or Country) New York
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs M Easterby
(Address) Nampa Ida
15. Filed June 4 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
5 (Month) 10 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 5-5- 1920, to 5-10 1920, that I last saw him alive on 5-10 1920, and that death occured on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Uremia
..... (Duration) days ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) H E Robinson M. D.
5-29 1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Polelawn Cem — DATE OF BURIAL: 5-12 1920
20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

Robin

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30389
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1004
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Edward Parsons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Mar (Month) 1 (Day) 1916 (Year)

7. AGE: 4 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... /
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. E. Parsons

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Susie D Newton

13. BIRTHPLACE OF MOTHER (State or Country) Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Parsons
(Address) Nampa Ida

15. Filed May 27 1920 Pearle Dodds, Local Registrar
Ross

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Apr - May 29 - 8th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 29-1920, to May-8th-1920, that I last saw him alive on Apr. 8th 1920, and that death occured on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia Meningitis
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Thos E. Maughan M. D.
5-26 1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerdown Cem — DATE OF BURIAL: 5-10 1920

20. UNDERTAKER: Fred K. Robertson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 30390
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. 302 - 9th Ave. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret A Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 25 (Day) 1871 (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: C. Davidson

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Jane Collins

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M M Davidson
(Address) Nampa Ida

15. Filed May 24 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1918, to May 16 1920, that I last saw her alive on May 16 1920, and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Insufficiency
.....
.....
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Hemiplegia
(Duration ..... yrs. 6 mos. ..... ds.
(Signed) H. P. Rose M. D.
5/17 1920 (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: May 18 1920

20. UNDERTAKER: Fred K. Robertson — ADDRESS: Nampa

SYMS - YORK CO., PTRS. & BOOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 30391
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel Francis Spurlock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, [redacted] (Write the word.)

6. DATE OF BIRTH. July (Month) 22 (Day) 1919 (Year)

7. AGE: ..... Yrs. 10 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Oregon

10. NAME OF FATHER Frank Spurlock

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Mabel Rankin

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Spurlock
(Address) Nampa Ida

15. Filed May 27 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1920, to May 26 1920, that I last saw her alive on May 26 1920, and that death occured on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
.....
.....
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Malnutrition
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Geo R Proctor M. D.
5/27 1920 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerstown Cem. DATE OF BURIAL: 5-27 1920

20. UNDERTAKER: F. R. Robinson ADDRESS: Nampa

Proctor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30392

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 3 (Day) 1862 (Year)

7. AGE: 57 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) N. C.

10. NAME OF FATHER Robert Johnson

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Nancy Sloan

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Effie J. Johnson

(Address) Malad Ida

15.

Filed May 27 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-16 1920, to 5-26 1920, that I last saw him alive on 5-24 1920, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H E Robinson M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Middleton Cem — DATE OF BURIAL: 5-27 1920

20. UNDERTAKER: F K Robinson — ADDRESS: Lava

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9

Primary Registration District No.

File No. 36393

Registered No.

1. PLACE OF DEATH.

County of Ada

City of Star

(No. Star St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie Melissa Mc. Donald Leslie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) married

6. DATE OF BIRTH. April (Month) 24 (Day) 1872 (Year)

7. AGE 47 Yrs. Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... home wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Middleton, Idaho

10. NAME OF FATHER Francis H. McDonald.

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Emmaliza Heckendorn.

~~Married Mc. Ne.~~

13. BIRTHPLACE OF MOTHER (State or Country) Indiana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dora E. Douglas.

(Address) Star Idaho 3 7 6

15.

Filed May 20 1920 F. A. Lewis, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1920, to May 16 1920, that I last saw h[illegible] alive on May 16 1920 and that death occured on the date stated above, at 10 A. M.

The **CAUSE OF DEATH*** was as follows:

Cancerage Stomach,

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Alcerate Stomach

(Duration) ..... yrs. ..... mos. May ds.

5/16 1920 (Signed) [illegible] M. D.

(Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Star Cemetery — **DATE OF BURIAL** 5/19 1920

20. UNDERTAKER Schreiber & Heidenfelder — **ADDRESS** Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Soda Springs
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2048
(No. ....., ... St.)

File No. 30394
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martina Elizabeth Boon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED.~~ (*Write* the word.)
F	W	

6. DATE OF BIRTH: June (Month) 15 (Day) 1919 (Year)

7. AGE: 1 yrs. 5 mos. 15 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Ethel Boon

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Mary Odell

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ed Wheelwright
(Address) Soda Springs Ida

15.
Filed May 28, 1920 Ezra Lacey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 28, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1920 to May 28 1920
that I last saw h[illegible] alive on May 28 1920
and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Convulsions

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Pertussis

..... (Duration) ..... yrs. ..... mos. 20 ds.

(Signed) Ezra Lacey M. D.
May 28 1920 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Soda Springs Ida	May 30 1920
20. UNDERTAKER	**ADDRESS**
Ed Wheelwright	Soda Springs Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30395

Registered No. 10

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

County of Canyon

City of Cedar Springs Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Tindall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. ~~SINGLE, MARRIED~~, WIDOWED ~~OR DIVORCED~~. (*Write* the word.)

6. DATE OF BIRTH: Not Known (Month) (Day) 1 (Year)

7. AGE: Not Known ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Pumping Engineer

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gladys Peck
(Address) Cedar Springs, Idaho

15.
Filed May 3, 1920 Ellis Kackley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 3, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1920, to May 3 1920, that I last saw h[illegible] alive on May 3, 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

..... (Duration) ..... yrs. 6 mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ellis Kackley M. D.
May 3 1920 (Address) Cedar Springs, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boughman Canyon	May 4 1920
20. UNDERTAKER	**ADDRESS**
Schuster & Hall	Nampa Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2083
File No. 30396
Registered No.

1. PLACE OF DEATH
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph L. Caldwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Jan. (Month) 19 (Day) 1862 (Year)

7. AGE: 58 Yrs. 4 Mos. 8 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Professor.
(b) General nature of industry, business or establishment in which employed (or employer): Post Master

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Joseph Caldwell

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Reynolds

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Verne C. Caldwell
(Address) Meridian, Idaho

15. Filed May 27 1920 Alice A. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1920 (Year)
~~May 27~~ May 27. 1920

17. I HEREBY CERTIFY, That I attended deceased from May 27 1920 to May 27 1920
that I last saw him alive on May 27 1920
and that death occurred on the date stated above, at 3 P. M.,
The CAUSE OF DEATH* was as follows:
Acute Lungina Pectoris.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. L. Dutton M. D.
5/27 1920 (Address) Meridian Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill. DATE OF BURIAL: May 30 1920

20. UNDERTAKER: M. Smoker ADDRESS: Meridian Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 2003
File No. 30397

1. PLACE OF DEATH

County of
City of
(No. , St.)
Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Thomas Daly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 9 (Day) 1867 (Year)

7. AGE: 53 Yrs. Mos. 13 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Daly

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Sarah Ellis

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. J. Daly
(Address) Meridian Idaho

15. Filed May 24 1920 Alice A. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) — 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug - 1920 to May-22 1920
that I last saw him alive on May-14 1920
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma - Stomach
Secondary Liver

(Duration) Yrs. mos. ds.
Contributory (Secondary) Primary of Stomach
(Duration) 1 yr. mos. ds.

(Signed) W. L. Dutton M. D.
5/27 1920. (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverview — DATE OF BURIAL: May 24 1920

20. UNDERTAKER: W. B. Mullen — ADDRESS: Meridian

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 30398
Registered No.

1. PLACE OF DEATH
County of Ada
City of Meridean
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ortha Hughes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: March 8 1836 (Month) (Day) (Year)

7. AGE: 84 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Perrysville Indiana

10. NAME OF FATHER: Geo Hughes

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey Hughes
(Address) Meridian Idaho R.F.D. No 3

15. Filed June 6 1920 Alice A. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 4 1920 (Month) (Day) (Year) 6:30 PM

17. I HEREBY CERTIFY, That I attended deceased from May 18 1920 to June 4 1920 that I last saw h[illegible] alive on May 18 1920 and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) Yrs. Several mos. ds.
Contributory (Secondary) Senility
(Duration) Several yrs. mos. ds.

(Signed) W S Lutes M. D.
6-5 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery DATE OF BURIAL: June 6 1920

20. UNDERTAKER: W B Nichols ADDRESS: Meridian Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
(No. .....) ..... St.)

File No. 30400
Registered No. 19

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Jackson Lasure

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH. Jan 21 1836
(Month) (Day) (Year)

7. AGE: 84 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penna

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) William J. Irbe
(Address) Shoshone

15. Filed May 19 1920
J. L. Fuller
Local Registrar

SYMS - YORK CO., TYPES. & RUBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1920, to May 19 1920, that I last saw h[illegible] alive on May 19 1920 and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Senile Gangrene

(Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) Senility
(Duration) 4 yrs. 2 mos. ..... ds.
(Signed) [signature] M. D.
5-20 1920 (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone
DATE OF BURIAL: 5-20 1920

20. UNDERTAKER: O. F. Brennan
ADDRESS: Shoshone

FORM V. S. No. 5-2 [illegible] 1-10-16

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
File No. 30401
Registered No. 16

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Silas L Cook

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): widower
6. DATE OF BIRTH. 8 of March 1854 (Month) (Day) (Year)
7. AGE: 68 Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry; business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: John Cook
11. BIRTHPLACE OF FATHER (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): O[illegible]
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lawrence D Cook
(Address) Richfield
15. Filed May 17" 1920 J L Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16. (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 16 1920, to May 16 1920, that I last saw h[illegible] alive on May 16 1920 and that death occured on the date stated above, at 6 30 P.M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Exhaustion
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
May 17 1920 (Address) Shoshone Ida.

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State 20 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Richfield Ida
Former or usual residence [illegible]

19. PLACE OF BURIAL OR REMOVAL: Shoshone — DATE OF BURIAL: May 17 1920
20. UNDERTAKER: O J Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1616
(No. .... St.)

File No. 30402
Registered No. 77

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Lansing Palmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. March 11 1882 (Month) (Day) (Year)
7. AGE: 38 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Centralia Wash
10. NAME OF FATHER John Palmer
11. BIRTHPLACE OF FATHER (State or Country) N. D. A
12. MAIDEN NAME OF MOTHER Julia Romly
13. BIRTHPLACE OF MOTHER (State or Country) Washington St
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Maudie Duncan
(Address) Pocatello Idaho
15. Filed May 14 1920 J L Fuller Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 13 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 4 1920, to May 13 1920, that I last saw h[illegible] alive on May 13 1920 and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Acute Peritonitis
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) Ruptured Appendix
(Duration Yrs. mos. 10 ds.
(Signed) ..... M. D.
May 13 1920 (Address) .....

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 10 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? Shoshone Ida
Former or usual residence Shoshone Ida

19. PLACE OF BURIAL OR REMOVAL: Yakima Wash
DATE OF BURIAL: .....191.....
20. UNDERTAKER: O F Brennan
ADDRESS: Shoshone

SYMS - YORK CO., Print. & Stats. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 30403
Registered No. 32

1. PLACE OF DEATH
County of Minidoka
City of Paul
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Logan J. Bacon
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 6 (Day) 1868 (Year)

7. AGE: 51 Yrs. ..... Mos. 11 ds. 22
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber & Picture Show opr
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Cyrus Bacon

11. BIRTHPLACE OF FATHER (State or Country): ~~Mo~~ Unknown

12. MAIDEN NAME OF MOTHER: Nole

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Bacon
(Address) Paul Idaho

15. Filed 6-7 1920 E. M. Ehmcke Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 28 (Month) 1920 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 19 20 to May 28 19 20 that I last saw h[illegible] alive on May 26 19 20 and that death occurred on the date stated above, at 2 M.
The CAUSE OF DEATH* was as follows: Pneumonia Lobular
of Grippe Influenza
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. F. Adams M. D.
5-30 19 20 (Address) Paul, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portland Oregon
DATE OF BURIAL: 6-2 1920

20. UNDERTAKER: W. A. Goodman J. P. S.
ADDRESS: Rupert Ida

FORM V. S. No. 5-25 M. 1-19.

Dr Patterson

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30404

Registered No. 35

1. PLACE OF DEATH

County of Minidoka

City of Rupert Ida

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bula Perry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 3 (Day) 1887 (Year)

7. AGE: 32 Yrs. ..... Mos. 9 ds. 27

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Springville Utah

10. NAME OF FATHER: L. Whiting

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: Fanny Johnson

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. S. Perry

(Address) Rupert Ida

15. Filed 6 - 7 1920 E. E. Elmore — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1920 to May 30 1920 that I last saw h.er alive on May 29 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Hyperthermydiasis

(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.

5-30 1920 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Provo Utah

DATE OF BURIAL: June 2 1920

20. UNDERTAKER: W. A. Goodsman

ADDRESS: Rupert Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 30405
Registered No. 34

1. PLACE OF DEATH
County of Minidoka
City of Paul
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Delma Haynes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. 10 1909 (Month) (Day) (Year)

7. AGE: 10 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hooper Utah

10. NAME OF FATHER: Geo Haynes

11. BIRTHPLACE OF FATHER (State or Country): Hooper.

12. MAIDEN NAME OF MOTHER: Dora Jones

13. BIRTHPLACE OF MOTHER (State or Country): Hooper Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dora Haynes
(Address) Paul Ida

15. Filed 6-7 1920. E. W. Ehmcke Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 30 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1920 to May 29 1920 that I last saw h[illegible] alive on [illegible] May 29 1920 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.... (Duration) .... Yrs. .... mos. .... ds.

Contributory (Secondary)

.... (Duration) .... Yrs. .... mos. .... ds.

(Signed) W. E. Rayburn M. D.

5/31 1920 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Ida — DATE OF BURIAL: June 1 1920

20. UNDERTAKER: W. H. Goodman — ADDRESS: Rupert

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2013

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30406

Registered No. 35

1. **PLACE OF DEATH**

County of Minidoka

City of Rupert

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Fem

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Child

6. **DATE OF BIRTH**: May (Month) 24 (Day) 1920 (Year)

7. **AGE**: Stillborn — Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 3 hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. **BIRTHPLACE** (State or Country): Idaho

10. **NAME OF FATHER**: Joe Gessler

11. **BIRTHPLACE OF FATHER** (State or Country): Switzerland

12. **MAIDEN NAME OF MOTHER**: Agnes Rogoman

13. **BIRTHPLACE OF MOTHER** (State or Country): Austria

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Joe Gessler

(Address) Rupert Idaho

15.

Filed ..... 19 .....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: May (Month) 24 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Stillborn

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Ramsey M. D.

1920 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: IOOF Cemetery — **DATE OF BURIAL**: May 25 1920

20. **UNDERTAKER**: W. G. Goodman — **ADDRESS**: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30407
Registered No. 67

Registration District No. 19
Primary Registration District No. 2015

1. PLACE OF DEATH
County of Minidoka
City of Rupert
If death occurs away from usual residence give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME T. Y. Shiogawa

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 4 1920
(Month) (Day) (Year)

7. AGE: 0 Yrs. 2 Mos. 5 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: K. Shiogawa

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: T. Horgasa

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) K. Shiogawa
(Address) Paul Ida

15.
Filed 6-7 1920
E. E. Elmore
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 9 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1920 to May 9 1920
that I last saw him alive on May 9 1920
and that death occurred on the date stated above at 7 a M.

The CAUSE OF DEATH* was as follows:
Enteric-typhoid
(Duration) Yrs. 1 mos. 4 ds.
Contributory (Secondary) Pulmonitis
(Duration) Yrs. mos. 2 ds.
(Signed) H. H. Robinson M. D.
6-7 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Ida — DATE OF BURIAL: 6-10 1920

20. UNDERTAKER: R. W. Watt — ADDRESS: Burley Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30408

Registered No. 37

1. PLACE OF DEATH

County of Cassia

City of Jackson

(No. ..... St.)

Registration District No. 19

Primary Registration District No. 2015

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Elizabeth Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	single

6. DATE OF BIRTH: April 26 1920 (Month) (Day) (Year)

7. AGE: ---- Yrs. 1 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Idaho

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: Maggie Evans

13. BIRTHPLACE OF MOTHER (State or Country): Colo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. L. Evans Jr. R. F. D.
(Address) Jackson Ida

15. Filed June 7 1920 E. B. Elmore Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 25 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1920, to May 25 1920, that I last saw her alive on May 24 1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Small Pox

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

6-7 1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jackson Cemetery	5-26 1920

20. UNDERTAKER	ADDRESS
W. A. Goodman & Co.	Rupert, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Death due to smallpox

disinterment request
denied by St. Registrar
10-27-83

see disinterments
issued file 11-4-83
JRA

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30409

Registered No.

Registration District No.

Primary Registration District No. 21

(No. , St.)

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Malvina Wilson Bell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: August (Month) 28 (Day) 1837 (Year)

7. AGE: Yrs. 82 Mos. 8 ds. 8

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Carl Co Mo.

10. NAME OF FATHER: William Wilson

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Wm Justice

(Address) Hagerman Idaho

15. Filed June 14 1920 R N Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May. (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1920 to May 6 1920 that I last saw her alive on May 6 1920 and that death occurred on the date stated above, at 11 30 M.

The CAUSE OF DEATH* was as follows: Paralysis of throat

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) R N Greene M. D.

19 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hagerman — DATE OF BURIAL: May 7. 1920

20. UNDERTAKER: Jones — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30416
Registered No.

Registration District No.
Primary Registration District No. 21
(No. , St.)

1. PLACE OF DEATH
County of Gooding
City of Wagenman
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lila Belle Terry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single
6. DATE OF BIRTH: March (Month) 3 (Day) 1920 (Year)
7. AGE: Yrs. Mos. 17 ds. IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Gooding Co Ida
10. NAME OF FATHER: Robt J Terry
11. BIRTHPLACE OF FATHER (State or Country): Mo
12. MAIDEN NAME OF MOTHER: Florence E Delmare
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Robert J Terry
(Address): Wagenman Ida
15. Filed May 31 1920 — P R Greene, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 14 1920, to Mar 17 1920, that I last saw h-r alive on Mar 17 1920, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Influenza with Milk infection
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) P H Greene M. D.
May 31 1920 (Address) Wagenman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death? Infant
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wagenman — DATE OF BURIAL: Mar 1920
20. UNDERTAKER: None — ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30411

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Hagerman

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 21

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vera Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 4 (Day) 1885 (Year)

7. AGE: 35 Yrs. 10 Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tooele Utah

10. NAME OF FATHER: Porter M. Miles

11. BIRTHPLACE OF FATHER (State or Country): Oswego N.Y.

12. MAIDEN NAME OF MOTHER: Libby Rowberry

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. M. Miles

(Address) Hagerman Ida

15. Filed Feb 17 1920 R W Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 6 1920 to Feb 14 1920 that I last saw h[illegible] alive on Feb 14 1920, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Influenza with Pneumonia
& Abortion 3 months duration

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary) General Toxine

(Duration) yrs. mos. 4 ds.

(Signed) R W Greene M. D.

Feb 1920 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Hagerman

Former or usual residence Hagerman

19. PLACE OF BURIAL OR ~~REMOVAL~~: Hagerman DATE OF BURIAL: Feb 17 1920

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30413
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Wagenman
(No. St.)
Registration District No.
Primary Registration District No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Della Winnifred Condit

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Dec (Month) 3 (Day) 1919 (Year)

7. AGE: Yrs. 2 Mos. month Ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wagerman

10. NAME OF FATHER: Winford Condit

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Nash

13. BIRTHPLACE OF MOTHER (State or Country): S. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Percy Parks
(Address) Wagerman

15. Filed Feb 8 1920 R H Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3 1920, to Date 19..., that I last saw h. her alive on Feb 3 1920, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory (Secondary) Stomach Complication

(Duration) four days Yrs. mos. ds.

(Signed) R. H. Greene M. D.

May 19 20 (Address) R H Greene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wagerman | DATE OF BURIAL: Feb 4 1920

20. UNDERTAKER: None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Gooding
City of Wagenman
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 21
(No. , St.)

File No. 30414
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Newell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 25 1888 (Month) (Day) (Year)

7. AGE: 32 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: D A Pulley

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Lydia Moon

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lester Newell
(Address) Jerome Ida

15. Filed Mar 15 1920 R N Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 5 1920 to Mar 7 1920 that I last saw her alive on Mar 7 1920 and that death occurred on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Influenza
with complications Heart failure
(Signed) R N Greene M. D.
Mar 9 1920 (Address) Wagenman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death? Flu at Jerome
Former or usual residence Jerome Ida

19. PLACE OF BURIAL OR REMOVAL: Wagenman Ida | DATE OF BURIAL: Mar 10 1920

20. UNDERTAKER: Thompson (Gooding) | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30415

1. PLACE OF DEATH

Registration District No. .....

Primary Registration District No. 21

County of .....

City of ..... (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Foster Crane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan 18 — 20
(Month) (Day) (Year)

7. AGE: 1 Month
Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Hagerman

10. NAME OF FATHER: F Crane

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Bertha Addis

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F Crane
(Address) Hagerman

15. Filed April — 1920 R W Greene
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920 to Feb 13 1920 that I last saw h. alive on Feb 13 1920, and that death occurred on the date stated above, at 11 P M.

The ~~CAUSE~~ OF DEATH* was as follows: Pneumonia following Flu

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R W Greene M. D.

Apr 7 1920 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hagerman Cemetery — DATE OF BURIAL: Feb 14 1920

20. UNDERTAKER: Moore — ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 30416
Registered No. .....

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Austin Wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. 5 (Month) — 4 (Day) — 1883 (Year)

7. AGE: 37 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Rancher & Meat cutter
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER: Jessie Wood

11. BIRTHPLACE OF FATHER
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER: Emma Stafford

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. L. Stanfield
(Address) Gooding Idaho

15.
Filed 6 — 8 — 1920
F. T. Carey
Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
6 (Month) — 7 (Day) — 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h... alive on — 191...,
and that death occured on the date stated above, at 5 40 P.M.

The CAUSE OF DEATH* was as follows:
Drowning — while trying to rescue son from drowning

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....
.....(Duration .....yrs.....mos.....ds.

(Signed) L. W. Carey M. D.
6/8 1920 (Address) Gooding Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Idaho
DATE OF BURIAL: 6 — 10 — 1920

20. UNDERTAKER: C. E. Thompson
ADDRESS: Gooding

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 30417
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Gooding
City of Gooding

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond Custin Wood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. Single (Write the word.)

6. DATE OF BIRTH. Aug (Month) — 20 (Day) — 1907 (Year)

7. AGE 12 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... School Boy

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Miss. Oklahoma

10. NAME OF FATHER Marion Custin Wood

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Marie Stanfield

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. L. Stanfield

(Address) Gooding

15.

Filed 6 — 8 — 1920

F. W. Cary M. D.
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 (Month) — 7 (Day) — 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — **191**..., **to** ... **191**...,

that I last saw h... alive on ... **191**...

and that death occured on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Drowning

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

(Duration ... yrs. ... mos. ... ds.

(Signed) F. W. Cary M. D.

6/8 1920 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Gooding — **DATE OF BURIAL** 6-10-1920

20. UNDERTAKER A. E. Thompson — **ADDRESS** Gooding

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30418

Registered No. .....

1. PLACE OF DEATH.

County of Blaine Co

City of Fairfield

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Brum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 22 (Day) 1897 (Year)

7. AGE: 23 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J F Brum

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Monette Terry

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edsie Brum

(Address) Fairfield Idaho

15. Filed 5 11 1920

Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) — 11 (Day) — 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-5 1920, to 5-11 1920, that I last saw him alive on 5-11 1920 and that death occured on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:

Injury by Bruy kicked by horse in abdomen with resulting complication

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr ..... M. D.

May 11 1920 (Address) Fairfield Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Newark Idaho | DATE OF BURIAL: May 12 1920

20. UNDERTAKER: A E Thompson | ADDRESS: Fairfield

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1917-2017
File No. 30419
Registered No.

1. PLACE OF DEATH
County of Jerome
City of Jerome
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Weston Shuler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: March 26 (Month) (Day) 1920 (Year)

7. AGE: ....Yrs. ....Mos. 3 ds.
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jerome Idaho

10. NAME OF FATHER: A B Shuler

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Ora Miller

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr A. B. Shuler
(Address) Jerome Idaho

15. Filed March 29 1920 — E. D. Pifer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 26 1920, to March 29 1920, that I last saw h[illegible] alive on March 28 1920, and that death occurred on the date stated above, at 11:30 M.
The CAUSE OF DEATH* was as follows:
Hemophilia.

....(Duration) ....Yrs. ....mos. 3 ds.
Contributory (Secondary)
....(Duration) ....yrs. ....mos. ....ds.

(Signed) Edward D. Pifer M. D.
3/29 1920 (Address) Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary — DATE OF BURIAL: Mar 30 1920
20. UNDERTAKER: D. A. Roberson — ADDRESS: Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30420

Registered No.

1. PLACE OF DEATH

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23

Primary Registration District No. 1027 - 2017

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John C. Ritchey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: Aug (Month) 28 (Day) 1806 (Year)

7. AGE: 63 Yrs. 7 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Matthew D. Ritchey

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary G. Craig

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo F. Ritchey
(Address) Jerome, Ida.

15. Filed May 28 1920 E. D. Piper Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apl 21 1920 to Apl 22 1920 that I last saw h.... alive on Apl 21 1920, and that death occurred on the date stated above, at 9 10 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) John F Schmerstall M. D.

Apl 26 1920 (Address) Jerome Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome Cem.	April 24 1920

20. UNDERTAKER	ADDRESS
D. A. Litherland	Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30421

Registered No.

1. PLACE OF DEATH

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23

Primary Registration District No. 1017

(No. 2017 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Petersen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: April (Month) 28 (Day) 1873 (Year)

7. AGE: 46 Yrs. 11 Mos. 26 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Fritz Petersen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dorat Knaus

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dow b Purdum.

(Address)

15. Filed May 28 1920

E. D. Richards
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental Discharge of Shot Gun

(Duration) Instantly Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John F Kinnebrew M. D. Coroner

4/28 19 20 (Address) Jerome Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1017-2017
File No. 30422
Registered No.

1. PLACE OF DEATH
County of Jerome
City of Jerome
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Frances Ridell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: (Month) (Day) 1 (Year)

7. AGE: 66 Yrs. 6 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Fuller

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Dent Thomas

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. E. Ridell
(Address) Death Ness,

15. Filed May 28 1920
E. D. Piper M. D.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 5 1920, to May 24 1920, that I last saw her alive on May 24 1920, and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:
Acute Bronchitis

(Duration) Yrs. mos. 40 ds.
Contributory (Secondary) Chronic Rheumatism
(Duration) 20 yrs. mos. ds.
(Signed) J. M. F. Schmershall M. D.
May 28 1920 (Address) Jerome Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Death Ness,
DATE OF BURIAL 19

20. UNDERTAKER: D. A. Johnson
ADDRESS Jerome

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 3042
Registered No. 100

1. PLACE OF DEATH.
County of Power
City of American Falls (No. B Ethans Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howell, Max Charles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. 2 (Month) (Day) 1890 (Year)

7. AGE: 30 Yrs. 6 mo. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Telegrapher
(b) General nature of industry, business, or establishment in which employed (or employer)... R.R. Co. Engaged since then up to 1914

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: James Howell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ellen Farnham

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James A. Howell
(Address) American Falls, Idaho

15. Filed 5/30 1920 R. F. Mork Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26th 1920 to May 29 1920, that I last saw him alive on May 29 1920 and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Epilepsy
about
(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

5/30 (Signed) Richard F Mork M. D.
5/30 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Falls Cemetery — DATE OF BURIAL: 5/31/1920

20. UNDERTAKER: Arthur Davis — ADDRESS: Am. Falls, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2119
(No. ..... St.)

File No. 30424
Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Franklin
City of Weston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stena McCullough

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct (Month) 13 (Day) 1866 (Year)

7. AGE: 57 Yrs. 6 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Hick Park Utah

10. NAME OF FATHER Forderman Fredrickson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Mette Jensen

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Raymond W Culloch
(Address) Weston Idaho

15. Filed June 1 1920 Dan Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 12 1920, to May 6 1920, that I last saw her alive on April 12 1920, and that death occured on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:
Leakage of Heart

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) Thos B Holden M. D.
19 (Address) Weston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weston Idaho — DATE OF BURIAL: 5-9 1920

20. UNDERTAKER: June — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
(No. ..... , ... St.)

File No. 30425
Registered No. 45

1. PLACE OF DEATH.
County of Bannock
City of Lava Hot Springs

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilora Chadwick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
female	white	single

6. DATE OF BIRTH. Aug (Month) ..... (Day) 1907 (Year)

7. AGE 12 Yrs. 9 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Preston Ida

10. NAME OF FATHER Wm. Chadwick

11. BIRTHPLACE OF FATHER (State or Country) not known

12. MAIDEN NAME OF MOTHER Ruth A Crockett

13. BIRTHPLACE OF MOTHER (State or Country) not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ivy Crockett
(Address) Lava Hot Springs Ida

15. Filed 6/7 1922 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 24 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1922, to May 24 1922, that I last saw h[illegible] alive on May 24 1922, and that death occured on the date stated above, at 4:30 P M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) ..... Yrs. almost a min. mos. ..... ds.
Contributory (Secondary) Heart failure resulting from presence of gas in Stomach
(Duration) ..... yrs. ..... mos. 1/2 ds.
(Signed) O. P. Keening M. D.
19..... (Address) Lava Hot Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State 12 yrs.....mos.....days
Where was disease contracted if not at place of death? at place of death
Former or usual residence Preston Ida

19. PLACE OF BURIAL OR REMOVAL Preston, Idaho — DATE OF BURIAL 191

20. UNDERTAKER Linquist — ADDRESS Preston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 30426
Registered No. 424

1. PLACE OF DEATH
County of Franklin
City of Winder (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret Rigby
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: Feb (Month) 6 (Day) 1844 (Year)

7. AGE: 76 Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Charles Duncan

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margaret Cook

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. Rigby
(Address) .....

15. Filed 6/7 1920. D. A. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1920, to May 27 1920, that I last saw h[illegible] alive on May 24 1920, and that death occurred on the date stated above, at 7A M.

The CAUSE OF DEATH* was as follows:
Arterio-sclerosis
(Duration) ✓ Yrs. ..... mos. ..... ds.
Contributory (Secondary) Cardiac hypertrophy
(Duration) ✓ yrs. ..... mos. ..... ds.

(Signed) Curtis Hand M. D.
5/27/1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Winder

19. PLACE OF BURIAL OR REMOVAL: Centerville Utah | DATE OF BURIAL: 5/30 1920

20. UNDERTAKER: C. A. Lundquist | ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 30427
Registered No. 42

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Russell S. Seamons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: September 12 1918 (Month) (Day) (Year)

7. AGE: 1 Yrs. 8 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: O. M. Seamons

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Ethel Shaffer

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. M. Seamons
(Address) Preston Idaho

15. Filed 6/7 1920 Dan B. Curtis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1920 to May 30 1920 that I last saw h~~im~~ alive on May 29 1920, and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Shocked to death
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) A. K. Cutler M. D.
5/30 1921 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: 5/31 1920

20. UNDERTAKER: G. A. Lundquist
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30428
Registered No. 45

1. PLACE OF DEATH
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Washington Bailey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH
Mar 1 1881
(Month) (Day) (Year)

7. AGE
39 Yrs. 2 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Professor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arizona

10. NAME OF FATHER: George W. Bailey

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Cynthia McClellan

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs G.W. Bailey
(Address) Salt Lake City, Utah

15. Filed 6/7 1920 Dan R. Cutler
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1920, to May 11 1920
that I last saw h.IM alive on May 11 1920
and that death occurred on the date stated above, at 4:40 M.

The CAUSE OF DEATH* was as follows:
Acute Tuberculosis of Lungs
Had had chronic T.B for
15 to 18 yrs
(Duration) 1 Yrs. ..... mos. 10 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. 21 ds.

(Signed) Curtis Hart M. D.
6/3 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake City	5/16 1920
20. UNDERTAKER C. A. Lundquist	ADDRESS Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30429
Registered No. 41

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)
Registration District No. 27
Primary Registration District No. 2
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Otto Emrich Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June 4 (Month) (Day) 1855 (Year)

7. AGE: 64 Yrs. 11 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Nels Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Christina

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert E. Johnson
(Address) Preston

15. Filed 6/7 1920 D. A. Dillard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 30 1920, to May 3 1920, that I last saw him alive on May 5 1920, and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Endocarditis.

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Rheumatism
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Allen R. Cutler M. D.
19..... (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: 5/29 1920

20. UNDERTAKER: G. L. Lundquist
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30430

Registered No. 31

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. 614 Pennsylvania St.)
Registration District No. 29
Primary Registration District No. 1050
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth R. Shipp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Feb (Month) 3 (Day) 1918 (Year)

7. AGE: 2 Yrs. 2 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER G. Shipp

11. BIRTHPLACE OF FATHER (State or Country) Kan.

12. MAIDEN NAME OF MOTHER Ida Furrow

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs L. A. Griffith
(Address) Marshall, Wash

15. Filed April 29 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1 1920, to April 27 1920, that I last saw h[er] alive on April 27 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia following Flue
..... (Duration) ..... Yrs. 4 mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. L. Grayman M. D.
4/28 1920 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. CDalene
DATE OF BURIAL: 4-29 1920

20. UNDERTAKER: C. Cassedy
ADDRESS: CDalene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 29

Primary Registration District No. 2050

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30431

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Nora Gregor Browning

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 9 (Day) 1896 (Year)

7. AGE: 24 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Dakota

10. NAME OF FATHER: Ole Gregor

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Helen Buslett

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edgar Browning Jr.
(Address) Fairmount Spokane

15. Filed June 4 1920 Gus Nelson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1920, and last saw h[illegible] alive on June 2 1920 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Wren M. D.

June 2 1920 (Address) C'dAlene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem — DATE OF BURIAL: 6-4 1920

20. UNDERTAKER: [illegible] Cassedy — ADDRESS: C'dAlene

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 30432
Registered No. 37

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene Ida
(No. 410 Hubbard St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henriretta Stricker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (Month) 30 (Day) 1845 (Year)

7. AGE: 75 Yrs. 0 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: B. F. Evans

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Malissa Mix

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. E. Stricker
(Address) Grand Forks N D

15. Filed June 3 1920 Gus Nelson Local Registrar

6YMS (YORK CO., PTRS. & SONS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
~~January~~ June 2 1920
(Month) (Day) ~~1920~~ (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1920, to June 2 1920, that I last saw her alive on June 2 1920, and that death occured on the date stated above, at 12.30 P.M.

The CAUSE OF DEATH* was as follows:
Acute intestinal obstruction.
(Paralytic ileus.)

(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Apoplexy.
(Duration) yrs. 1 mos. ds.

(Signed) John Allwood M. D.
June 2 1920 (Address) Coeur d'Alene Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery Coeur d'Alene
DATE OF BURIAL: 6-3 1920

20. UNDERTAKER: E. Cassedy
ADDRESS: C'Dalene

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 30433
Registered No. 36

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. 4th + Hattie St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Merle Barker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. January (Month) 19 (Day) 1896 (Year)

7. AGE: 24 Yrs. 4 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Horse
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Garfield Wn.

10. NAME OF FATHER: James Barker

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Hattie Giles

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Hattie Barker
(Address) Coeur D'Alene Ida

15. Filed June 3 1920 Gus Nelson Local Registrar

BYRNES-YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June May (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1920, to May 31 1920, that I last saw him alive on May 31 1920, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

June (Signed) J. C. Myers M. D.
May 1920 (Address) Coeur d'Alene Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary Coeur d'Alene
DATE OF BURIAL: 6-3 1920

20. UNDERTAKER: Cassedy
ADDRESS: C'dalene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 205-0
File No. 30434
Registered No. 36

1. PLACE OF DEATH.
County of Kootenai
City of Dalton Gardens (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Asbury L. Hudson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. May (Month) 1 (Day) 1854 (Year)

7. AGE: 66 Yrs. 0 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Thomas Hudson

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Elliott

13. BIRTHPLACE OF MOTHER (State or Country): ——

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Valerica Hudson
(Address) Dalton Gardens

15. Filed May 22 1920 Gus Nelson Local Registrar

SYMS-YORK CO., PTGS. & BDGS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 29 1920, to May 21 1920, that I last saw him alive on May 21 1920 and that death occured on the date stated above, at 4.30 P. M.
The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) One Yrs. mos. ds.
Contributory (Secondary) Cystitis and Prostatic Hypertrophy
(Duration 3 yrs. mos. ds.

(Signed) Louis H. Most M. D.
5/21 1920 (Address) Coeur d' Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: C. D'Alene. DATE OF BURIAL: 5-22 1920

20. UNDERTAKER: C Carsedy ADDRESS: C D'Alene

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30435

Registered No. 34

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 1450

(No. .... St.)

2. FULL NAME Margaret P. C. Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. December 29 (Month) (Day) 1903 (Year)

7. AGE: 16 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: scholar

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spokane Wn

10. NAME OF FATHER: W E Miller

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Elizabeth Mans

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Kate Miller

(Address) 1325 S Adams Spokane

15. Filed May 20 1920 Gus Nelson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1920 to May 19 1920, that I last saw h-- alive on May 19 1920, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Knedler M. D.

May 20 1920 (Address) Corner of Allen Wn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE OF BURIAL: 5-21 1920

20. UNDERTAKER: McConnell ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

111

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene No. 28 Garden St.)
Registration District No. 29
Primary Registration District No. 1050
File No. 30436
Registered No. 33

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louise Wandt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct (Month) 20 (Day) 1833 (Year)

7. AGE: 86 Yrs. 4 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Christ-J. Maltzen

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Wilhemena Norman

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Borek
(Address) Coeur D' Alene Ida

15. Filed May 2 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920, to May 1 1920, that I last saw her alive on May 1 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senile Heart-disease

(Duration) 7 Yrs. mos. ds.

Contributory (Secondary) Old age

(Duration yrs. mos. ds.

(Signed) D. D. Freeman M. D.
5/3 1920 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. C D'Alene — DATE OF BURIAL: May 3 1920

20. UNDERTAKER: C. Cassedy — ADDRESS: C D'Alene

BYNS - YORK CO., PTG. & SOBS. 24658

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1959
(No. 305, Coeur d'Alene St.)

File No. 30437
Registered No. 32

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marian Cora Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Widowed)

6. DATE OF BIRTH: July (Month) 24 (Day) 1864 (Year)

7. AGE: 55 Yrs. 10 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Hasco Nichols

11. BIRTHPLACE OF FATHER (State or Country): N. Y

12. MAIDEN NAME OF MOTHER: Desalana Wallace

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. D. Smith
(Address) 305 - C'Dalene Ave. C'D'A

15. Filed May 2 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 25 1920, to May 1 1920, that I last saw h.er alive on May 1 1920 and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:
Obstruction Gall duct with possibly a cancer of the Pancreatic involving the bowel
(Duration) Yrs. 7 mos. 15 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Worthington M. D.
5/1 1920 (Address) Coeur D'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Thomas. C'D'Alene | DATE OF BURIAL: May 4 1920

20. UNDERTAKER: C. Cassedy (Cemetery) | ADDRESS: C'D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051-2051
File No. 130438
Registered No. 11

1. PLACE OF DEATH
County of Kootenai
City of Bayview
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Lorania Spealman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: May (Month) 3. (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 7 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bayview, Idaho

10. NAME OF FATHER: Charles W. Spealman

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Blanche D. Moon

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. W. Spealman
(Address) Bayview, Idaho

15. Filed 6/1. 1920. Frank Mann Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3. 1920, to May 1920, that I last saw h.. alive on May 3- 1920, and that death occurred on the date stated above, at 8-00 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
(Coma 4 months gestation)
Atelectasis of Lungs 7 hrs.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank K Mann M. D.
5/4 1920 (Address) Potholum, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bayview, Ida. DATE OF BURIAL: May 4 1920.

20. UNDERTAKER: Oscar Hamilton ADDRESS: Bayview

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1 30439
Registered No. 12

1. PLACE OF DEATH.
County of Kootenai
City of Rathdrum
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30
Primary Registration District No. 1051-2051

2. FULL NAME Helen Bell Staddard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 23 (Day) 1878 (Year)

7. AGE: 41 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stayed at Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Edwin L. Staddard

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Helen Smith

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. L. Staddard
(Address) Rathdrum Ida

15. Filed 6/1. 1920. Frank Ware, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 22 1920, to May 11 1920, that I last saw h-r alive on May 11 1920 and that death occured on the date stated above, at 3.00 p M.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis
(Duration) about 4 Yrs. mos. ds.
Contributory (Secondary) Epidemic Influenza
(Duration) yrs. mos. 21 ds.

(Signed) Frank Ware M. D.
5/12 1920 (Address) Rathdrum Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Council Grove — DATE OF BURIAL: May 16 1920

20. UNDERTAKER: C. W. Stone — ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051-2051
File No. 30440
Registered No. 13

1. PLACE OF DEATH
County of Kootenai
City of Rathdrum
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rene Jr Grove
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 12, 1920 (Month) (Day) (Year)

7. AGE: ... Yrs. ... Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Chicco, Idaho

10. NAME OF FATHER: Rene Grove

11. BIRTHPLACE OF FATHER (State or Country): Kans.

12. MAIDEN NAME OF MOTHER: Esther Farwell

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rene Grove
(Address) Chicco, Idaho

15. Filed 5/27 1920 Frank Olney Local Registrar.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 26th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24, 1920 to May 26, 1920 that I last saw him alive on May 26, 1920, and that death occurred on the date stated above, at 9.25 M.

The CAUSE OF DEATH* was as follows:
Bronchio-Pneumonia
(Duration) ... Yrs. ... mos. 6 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Frank Olney M. D.
5/27 1920 (Address) Rathdrum, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene, Ida. DATE OF BURIAL: May 28 1920.

20. UNDERTAKER: C. W. Stone ADDRESS: Rathdrum Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30441

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1051-7051

(No. Clara Wright St.)

2. FULL NAME Clara Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. April 18 1905
(Month) (Day) (Year)

7. AGE: 15 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student +
(b) General nature of industry, business, or establishment in which employed (or employer)..... Lived on farm

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER James H. Wright

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Maud McGuire

13. BIRTHPLACE OF MOTHER (State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James H. Wright
(Address) Post Falls Idaho RFD

15. Filed 6/1 1920 Frank Wenz, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 31 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1920, to May 31. 1920, that I last saw h alive on May 31. 1920 and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Scarlet fever

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) Lobar Pneumonia

(Duration yrs. mos. 11 ds.

(Signed) Frank Wenz M. D.

6/1 1920 (Address) Rathdrum Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls Ida — DATE OF BURIAL: June 1 1920

20. UNDERTAKER: A W Stone — ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24858

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 30442
Registered No. 817

1. PLACE OF DEATH
County of Kootenai
City of Coeur d Alene
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Jayson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Aug (Month) 17 (Day) 1851 (Year)

7. AGE: 68 Yrs. 9 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Esquire N Billings

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Dyman

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Mable Jayson
(Address) Coeur d Alene

15. Filed June 9. 1920 D. V. Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1919, to May 28 1920 that I last saw h.. alive on May 28 1920, and that death occurred on the date stated above, at 4:15 P.M.
The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. W. Thurston, M. D.

5/28 1920 (Address) Coeur d' Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 8 mos. ..... days. In the State / yrs. / mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence North Dakota

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn — DATE OF BURIAL: May 31 1920

20. UNDERTAKER: C P B Mooney — ADDRESS: Cda Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1055
File No. 30443
Registered No. 876

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 513 — 3rd St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant David Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 27 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: David Thomas

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Agnes Laurence

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): David Thomas
(Address): Coeur d'Alene, Ida

15.
Filed June 2, 1920 D. D. Dreman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19— to — 19—
that I last saw h— alive on — 19—
and that death occurred on the date stated above, at 1 A. M.
The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) — Yrs. — mos. — ds.
Contributory (Secondary): Jaundice in Mother
(Duration) — yrs. — mos. — ds.
(Signed) W. H. Hoedemaker M. D.
6/26 1920. (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State — yrs. — mos. 4 days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: May 26 1920

20. UNDERTAKER: R. B. Mooney — ADDRESS: Coeur d'Alene

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 30444
Registered No. 815

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 1002 Lakeside St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo Edward Telford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 20 (Day) 1894 (Year)

7. AGE: 25 Yrs. 7 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: Geo Telford Sr.

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Hattie Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Telford Jr
(Address) Coeur d Alene Ida

15. Filed June 2 1920 D D Drennan, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1918, to May 22 1920, that I last saw h... alive on May 22 1920, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W H Hoedemaker M. D.
5/23 1920. (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 8 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: May 25 1920

20. UNDERTAKER: R B Mooney — ADDRESS: C d A

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1037
File No. 30445
Registered No. 814

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 9 d'A Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Truman A Gray
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 20 (Day) 1844 (Year)

7. AGE: 76 Yrs. 3 Mos. 0 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Truman Gray

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. H. Gray
(Address) RD 21 - 1st from Seattle Wn.

15. Filed June 1 1920 D. W. Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1920, to May 20 1920 that I last saw h.im alive on May 20 1920 and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ... Yrs. ... mos. few ds.
Contributory (Secondary) Senility
(Duration) ... yrs. ... mos. ... ds.
(Signed) Alexander Barclay M. D.
May 23 1920. (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State 3 yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Watertown Idaho — DATE OF BURIAL: May 25 1920

20. UNDERTAKER: C B Mooney — ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 10 31.
File No. 30446
Registered No. 812

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d' Alene
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Horace Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Feb (Month) 6 (Day) 1844 (Year)
7. AGE: 76 Yrs. 3 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country): New York.
10. NAME OF FATHER: W. C. Taylor
11. BIRTHPLACE OF FATHER (State or Country): New Hampshire
12. MAIDEN NAME OF MOTHER: Ann Newton
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mabel B. Taylor
(Address) Coeur d' Alene Ida.
15. Filed June 1 1920 D. D. Drennen Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 4 1920, to May 11 1920, that I last saw him alive on May 11 1920, and that death occured on the date stated above, at 8.20 A.M.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia
..... (Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Myocarditis
..... (Duration ..... yrs. ..... mos. 3 ds.
(Signed) C. D. Johnston M. D.
5/11 1920. (Address) Coeur d' Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs. 8 mos.....days. In the State. 1 yrs. 1 mos. 4 days
Where was disease contracted if not at place of death?.....
Former or usual residence Niagara, North Dakota

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn. DATE OF BURIAL: May 31 1920
20. UNDERTAKER: T B Mooney ADDRESS: C d'A Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 30447
Registered No. 813

1. PLACE OF DEATH
County of Kootenai
City of —
(No. Hayden Lake St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward J Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct 11 1860 (Month) (Day) (Year)

7. AGE: 59 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lessueur Co. Minn

10. NAME OF FATHER: Corlett Hill.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Cinderella Savidge

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Edward J Hill
(Address): Coeur d'Alene Ida

15. Filed June 1 1920 D.D. Brenner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 25 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1920 to May 17 1920 that I last saw h. alive on May 17 1920 and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:
Heart trouble
Dilatation
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bright's Disease
(Duration) 1 yrs. — mos. — ds.

(Signed) W. H. Hoeckers M. D.
5/23 1920. (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State / yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 5/23 1920

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051.
File No. 30448
Registered No. 811.

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. Reed Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Peters

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 28 (Day) 1864 (Year)

7. AGE: 56 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Christian Peters

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Kelting

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Otilla Evers
(Address) Almira Wn

15. Filed June 1 1920 W. D. Greuner Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 27 1920 to May 1 1920 that I last saw h.m. alive on May 1 1920 and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Uraemia Mercurio

(Duration) Not Known yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. D. Bays M. D.

May 1 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 1 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Almira Wash — DATE OF BURIAL: May 3 1920

20. UNDERTAKER: P. K. Mooney — ADDRESS: Pgh Pa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No.
File No. 1 30449
Registered No. 72

1. PLACE OF DEATH
County of Benewah
City of De Smit
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. W. Logan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Not known (Month) (Day) 1 (Year)

7. AGE: 56 (approx.) Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sawyer
(b) General nature of industry, business or establishment in which employed (or employer): Saw mill

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. McPhee
(Address) Farmington, Wash

15. Filed May 3 19 2
J. Le Bihan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 3 (Month) (Day) 19 2 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Sawmill accident
Accidental death

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) ..... M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR~~ Removal: Tekoa Wash
DATE OF BURIAL: May 4 19 2

20. UNDERTAKER: Carl Johnson
ADDRESS: Tekoa Wn

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No.
File No. 1 30451
Registered No. 14

1. PLACE OF DEATH
County of Benewah
City of Wenner
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Augustus Bishop

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 3 1847 (Month) (Day) (Year)

7. AGE: 73 Yrs. 2 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Benewah Co Ida.

10. NAME OF FATHER: Louis Bishop

11. BIRTHPLACE OF FATHER (State or Country): Coeur d'Alene Indian Reservation

12. MAIDEN NAME OF MOTHER: Rosalia

13. BIRTHPLACE OF MOTHER (State or Country): Coeur d'Alene Reservation

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Geo. J. Kinglen
(Address):

15. Filed 17 1920 Y. L. Bibbins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 16 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1920, to May 16 1920
that I last saw him alive on May 16 1920
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 7 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. A. Nelson M. D.
May 21 1920 (Address) Tensed Wash.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wenner — DATE OF BURIAL: May 19 1920

20. UNDERTAKER: J. Falcon — ADDRESS: Wenner

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, DENVER

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30452

Registered No. 20

Registration District No. 3-2

Primary Registration District No. 7049

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

~~City of~~ Ramsdell

2. FULL NAME Ellwood N. Colburne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Sept. (Month) 25 (Day) 1896 (Year)

7. AGE: 23 Yrs. 7 Mos. 26 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer): Hookman

9. BIRTHPLACE (State or Country): Charlevoix Mich

10. NAME OF FATHER: Wm E. Colburne

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Mattie S. Miller

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Elva C. Talbott

(Address) Marble Creek Ida.

15. Filed May 21 1920. H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1920, to same 191....., that I last saw h.....alive on .....191....., and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Accidental drowning
caused by rolling logs
off car in N Fork River

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) H L Adams Coroner ~~M. D.~~
D Benewah

May 21 1920 (Address) St Maries Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: On Arrival 191.....

20. UNDERTAKER: New England Und. Co ADDRESS: Spokane.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Benewah — Registration District No. 32
City of St. Maries, Ida. (No. ..... St.) — Primary Registration District No. 2049
File No. 30453
Registered No. 19
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME Noami Brady

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. December (Month) 10 (Day) 1862 (Year)
7. AGE: 57 Yrs. 5 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ontario, Canada
10. NAME OF FATHER: Henry Nelson
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Eliza Yearrow
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. L. Brady
(Address) Monroe, Wash.
15. Filed May 16 1920 — H E Hunt — Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 16 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 13 1920, to May 16 1920, that I last saw her alive on May 16 1920 and that death occured on the date stated above, at 3.30 P.M.
The CAUSE OF DEATH* was as follows:
Diabetes and heart
enaffeceency
(Duration) 7 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) Owen D Plaet M. D.
May 16 1920 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Monroe - Wash — DATE OF BURIAL 191
20. UNDERTAKER: H E Hunt Co — ADDRESS: St. Maries Id

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 30454
Registered No. 18

1. PLACE OF DEATH.
County of Benewah
City of St Maries
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Patterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1887 (Year)

7. AGE: 23 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER D K.

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs F Cunningham
(Address) St Maries

15. Filed May 7 1920 S E Hunt
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Basal Skull fracture
accidental injury

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

5/7 (Signed) S E Holcomb M. D.
19 20 (Address) St Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: 5/8 1920

20. UNDERTAKER: S E Hunt Co ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2059
(No. ....., ... St.)

File No. 30455
Registered No. 17

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Benewah
City of St. Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Woellner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Dec (Month) 26 (Day) 1900 ~~1800~~ (Year)

7. AGE 19 Yrs. 4 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Bridge laborer
(b) General nature of industry, business, or establishment in which employed (or employer)... for C. M & St. P.

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER William Woellner

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Emilia Lustig

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Otto Woellner
(Address) St. Maries

15. Filed May 5 1920 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Skull Fracture
Fractured Spine
(Duration) Immediate Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H E Cornwall M. D.
5/5 1920 (Address) St. Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mt Spokane Wn — DATE OF BURIAL Arrived 191

20. UNDERTAKER Mitchell & Menager — ADDRESS St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30456

1. PLACE OF DEATH.
Registration District No. 38
County of Bear Lake
Primary Registration District No. 2182
City of St. Charles (No. ....., ... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Neils Jenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: July (Month) 31 (Day) 1845 (Year)

7. AGE: 71 yrs. 0 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Jens Oksen

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: dont know

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ida Jansen
(Address) St. Charles, Idaho

15.
Filed May 29 1922 John Mattson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 15 (Day) 1922 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
no Dr in attendance
Death due to Heart failure

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Mattson M.D.
May 1922 (Address) St Charles Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles Id. | DATE OF BURIAL: May 15 1922

20. UNDERTAKER: John Mattson | ADDRESS: St Charles Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake

City of Bloomington

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 33

Primary Registration District No. #132

(No. ....., ... St.)

File No. 30457

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Journal Palmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 10 (Day) 1847 (Year)

7. AGE: 73 Yrs. ..... Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Isaac Palmer

11. BIRTHPLACE OF FATHER (State or Country): Iowa Known.

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15.

Filed ..... 19 .....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 7:35 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver.

.....

.....

.....(Duration). ....Yrs. 6 mos. .....ds.

Contributory (Secondary) .....

.....(Duration) ....yrs. .....mos. .....ds.

(Signed) J. Whitton M. D.

5/31/20 (Address) Paris Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bloomington	May 31 1920
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2023
File No. 30458
Registered No. 16

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Lockwood
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 69 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner & Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Maker

9. BIRTHPLACE (State or Country): New Haven Conn

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Addie H. Lockwood wife
(Address) Mountain Home B.W.M.

15. Filed Mar 5th 1920 Wm Maker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 6.00 P.M.
The CAUSE OF DEATH* was as follows:
Uremic poisoning
Arteriosclerosis
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm Maker M. D.
5-5-1920 (Address) Mountain Home

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home
DATE OF BURIAL: 5-6 1920

20. UNDERTAKER: A.E. Cowen
ADDRESS: Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 20 4
File No. 30459
Registered No. 18

1. PLACE OF DEATH

County of Kootenai
City of Ft Boise (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Ross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	married

6. DATE OF BIRTH: May (Month) 27 (Day) 1835 (Year)

7. AGE: 84 Yrs. 11 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Huron County Ontario Canada

10. NAME OF FATHER: Donald Ross

11. BIRTHPLACE OF FATHER (State or Country): Inverness Scotland

12. MAIDEN NAME OF MOTHER: Elizabath Fraser

13. BIRTHPLACE OF MOTHER (State or Country): Novascotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Ross
(Address) Stanmett Ida

15. Filed ..... 19.....
..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-27-1920, to 4-29-1920, that I last saw h— alive on —— 19....., and that death occurred on the date stated above, at 5:15A M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J E Evans M. D.

5-13-1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mtn Home Ida	4-31-1920

20. UNDERTAKER	ADDRESS
A. W. Conner	Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 4040
File No. 30461
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Jane Irwin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: May (Month) ..... (Day) 1844 (Year)

7. AGE: 76 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F J Irwin
(Address) Mtn Home Ida

15. Filed May [illegible] 1920 ..... Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1920, to May 6 19..., that I last saw her alive on May 6 1920, and that death occurred on the date stated above, at 5.00a M.

The CAUSE OF DEATH* was as follows: Suppurative Tonsilitis

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary): Mitral regurgitation
(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) F J Evans M. D.
5-3-1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Ida — DATE OF BURIAL: 5-7 1920

20. UNDERTAKER: A. W. Conover — ADDRESS: Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30462

Registered No.

1. PLACE OF DEATH.
County of Elmore
City of Glenn's Ferry (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2021

2. FULL NAME Ruthlen C. Enright

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Sept. (Month) 12 (Day) 1884 (Year)

7. AGE: 35 yrs. 7 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Mr Rolls

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theodore Enright
(Address) Glenn's Ferry Idaho

15.
Filed May 10 1920 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1920, to May 8 1920, that I last saw h.. alive on May 8 1920, and that death occurred on the date stated above, at 8 40 P M.

The CAUSE OF DEATH* was as follows:
Septic Phlebitis

(Duration) ..... yrs. ..... mos. 12 ds.
Contributory (Secondary) Fibroid Tumor
(Duration) ..... yrs. 4 mos. ..... ds.

(Signed) J. W. Davis M. D.
May 10 1920 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Los Angeles California — DATE OF BURIAL: May 10 1920

20. UNDERTAKER: Kenneth McBratney — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YORK CO., PRINTERS & BINDERS. BOISE 18672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 35
Primary Registration District No. 2021
File No. 30463
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Glenns Ferry Ida (No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Rosevear
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov 21" 1842 (Month) (Day) (Year)

7. AGE: 77 Yrs. 5 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Capitalist
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Luxulyan, Cornwall. England

10. NAME OF FATHER: William Rosevear

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Mark

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George H Rosevear
(Address) Glenns Ferry Ida

15. Filed May 16 1920 J. W. Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21st 1920 to May 13 1920 that I last saw him alive on May 13 1920, and that death occurred on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:
Cardiac Dilatation

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Bronchial Asthma
(Duration) 35 yrs. mos. ds.

(Signed) J. W. Davis M. D.
May 14 1920 (Address) Glenns Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Glenns Ferry Idaho — DATE OF BURIAL: May 16 1920

20. UNDERTAKER: Wm. McCluskey — ADDRESS: Glenns Ferry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 36
County of Twin Falls Primary Registration District No.
City of Kimberly (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 30464
Registered No. 11
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth Floyd Colby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH: April (Month) 13 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Floyd Jackson Colby

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Bernice Dollie Tull

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. J. Colby
(Address) Kimberly Idaho

15. Filed May 11 1920 J. M. Dawes Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1920, to May 10 1920, that I last saw him alive on May 10 1920, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... yrs. ..... mos. 2 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Dawes M. D.
5/10 1920 (Address) Kimberly Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rock Creek Ida. DATE OF BURIAL: 5-11 1920

20. UNDERTAKER: none ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 36

Primary Registration District No.

File No. 30465

County of Twin Falls

City of Rock Creek (No. , St.)

Registered No. 12

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Nelson Larsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
male	W	S (*Write* the word.)

6. DATE OF BIRTH: May (Month) 22 (Day) 1920 (Year)

7. AGE: ...yrs. ...mos. 1 ds. IF LESS than 1 day how many 8 *hrs. or* 25 *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Nephi Larsen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Olive Atkin

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nephi Larsen
(Address) Rock creek, Idaho

15. Filed May 23 1920 J.N. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1920 to May 23 1920
that I last saw h im alive on May 22 1920
and that death occurred on the date stated above, at 10:40A
The CAUSE OF DEATH* was as follows:

probably cerebral hemorrhage

(Duration) ...yrs. ...mos. ...ds.

Contributory (Secondary) Instrumental deliv.

(Duration) ...yrs. ...mos. ...ds.

(Signed) ... M. D.

19... (Address) Kimberly, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls, Idaho — DATE OF BURIAL: May 23 1920

20. UNDERTAKER — ADDRESS

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2085
File No. 30467
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Kimberly
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Patrick Kelly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~Single~~

6. DATE OF BIRTH: Oct (Month) 23 (Day) 04 (Year)

7. AGE: 9 Yrs. 6 Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Cartwright Kelley

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elezebeth Rocke

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. E. MacBlarney
(Address) R.R. #2 Kimberly

15. Filed May 20 1920 John F. Cauchlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:
Drowned. Accidental

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. J. Donovan M.D.
5/19 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: MAY 20 1920

20. UNDERTAKER: J. J. Donovan
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25-M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 30468
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Kimball
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vernon Lee Wright
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug. (Month) 3 (Day) 1919 (Year)

7. AGE: Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Roy L Wright

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Lillie Holliway

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy L. Wright
(Address) Twin Falls Idaho

15.
Filed 19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1920, to May 7 1920
that I last saw him alive on May 7 1920
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Sepsis Streptococcus infection

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. W. Saunders M. D.
5/8 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 5/9 1920

20. UNDERTAKER: J. J. Grossman
ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—20 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30409

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 2085
(No. ____, ____ St.)

2. FULL NAME James J. Maloney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Jan (Month) 31 (Day) 1861 (Year)

7. AGE: 59 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Thomas Maloney

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Anna Brigg

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. E. Williams
(Address) Filer R.F.D. 2

15. Filed May 8 1920 John F. Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1920 to May 3 1920 that I last saw him alive on May 3 1920, and that death occurred on the date stated above, at 12:15 P.M.
The CAUSE OF DEATH* was as follows:

Myo. Casdilis

(Duration) 2 Yrs. ____ mos. ____ ds.
Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) John F. Caughlin M. D.
5 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Ida.
DATE OF BURIAL ____ 19____

20. UNDERTAKER: J. F. Goodrich
ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Twin Falls

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 20 & 25

(No. ....., ... St.)

File No. 30470

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Peter Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Married

6. **DATE OF BIRTH** Mar 22 (Month) 22 (Day) 1882 (Year)

7. **AGE** 38 Yrs. 1 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work farmer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Sweeden

10. **NAME OF FATHER** Carl Gustamon

11. **BIRTHPLACE OF FATHER** (State or Country) Sweeden

12. **MAIDEN NAME OF MOTHER** Not Known

13. **BIRTHPLACE OF MOTHER** (State or Country) Sweeden

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Robt. Carlson

(Address) Rupert Route 3

15. Filed May 14 1920 John H Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** May (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1920 to May 13 1920 that I last saw h im alive on May 13 1920 and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs.

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Obstruction bowel and appendicitis

..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) J W Long M. D.

May 14 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Rupert Idaho — **DATE OF BURIAL** ..... 19.....

20. **UNDERTAKER** J E Hewett — **ADDRESS** Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30472

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 1082

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah E Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Divorced~~ Widowed

6. DATE OF BIRTH: May (Month) 10 (Day) 1852 (Year)

7. AGE: 68 Yrs. - Mos. 13 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business or establishment in which employed (or employer): General.

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: John L. Smith

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) Buhl Ida.

15. Filed June 2 1920 John Houghlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11 1920 to May 29 1920 that I last saw her alive on May 29 1920 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) don't Know yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr C M McGinnis M. D.

6/1 1920 (Addpess) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: June 4 1920

20. UNDERTAKER: P.F. Grossman — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30473
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph C Hamlin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: Sept (Month) 25 (Day) ~~1848~~ 1859 (Year)

7. AGE: 60 Yrs. 8 Mos. 3 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Harry Hamlin

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Amy Stockham

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J C Hamlin
(Address) Twin Falls, Ida.

15. Filed June 1 1920 John F Caughlan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-25 1920, to 5-28 1920
that I last saw h[illegible] alive on 5-28 1920
and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) E S Trueblood M. D.
5-29 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Twin Falls

19. PLACE OF BURIAL OR REMOVAL: ~~Foundry Hill~~ | DATE OF BURIAL 19

20. UNDERTAKER: J E Truett | ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 5108

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30474
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Billy Gary Killin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan 19 (Month) (Day) 1920 (Year)

7. AGE: 0 Yrs. 4 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Twin Falls

10. NAME OF FATHER: Joe Killin

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Marita Carr

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas R Killin
(Address) 827 Ash St Twin Falls

15. Filed May 29 1920 John F Caughlan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 26 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1920, to May 26th 1920 that I last saw him alive on May 24th 1920 and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease
.....(Duration) ..... Yrs. 4 mos. 7 ds.
Contributory (Secondary) Bronchitis
.....(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Herbert C Drane M. D.
5/27 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 5-27 1920

20. UNDERTAKER: J E Veatch — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of ( )

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

File No. 30475

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Ray Beals

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Aug 19 (Month) (Day) 1918 (Year)

7. AGE: Yrs. 9 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harry Beals

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Isabelle Keith

13. BIRTHPLACE OF MOTHER (State or Country): Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry S. Beals

(Address) Twin Falls, Ida

15. Filed May 22 1920 John F. Cauch Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-17 1920 to 5-21 1920 that I last saw h... alive on 5-21 1920 and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T Swanson M. D.

5-22 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 5-22 1920

20. UNDERTAKER: E E Wurst — ADDRESS: Twin Falls

BYNS-YORK CO., PRINTERS & BINDERS, BOISE 51097

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 1085
(No. ____, ____ St.)

File No. 30476
Registered No. ____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
Male	White	Single

6. DATE OF BIRTH: August (Month) 16 (Day) 1897 (Year)

7. AGE: 23 Yrs. 8 Mos. 23 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Vulcanizer.
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: C. C. Anderson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Mary ann Simpson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Anderson
(Address) 1479 South 2nd East. Salt Lake City

15. Filed May 15th 1920 John F. Cavanaugh Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1920, to May 9th 1920, that I last saw h.im alive on May 9th 1920, and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows: Cerebral hemorrhage
Poisoning by drinking Florida water & other toilet preparations - Wood alcohol
(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) ____
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) John F. Coughlin M. D.
5-17-1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake City.	19
20. UNDERTAKER	ADDRESS
J. J. Groesbeck	Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 5108

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Lawyer.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30477

Registered No.

Registration District No. 31

Primary Registration District No. 1085

1. PLACE OF DEATH

County of Twin Falls

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Esther Marjorie Lykins

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 21 (Day) 19 9 (Year)

7. AGE: 1 Yrs. 7 Mos. 26 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: J.C. Lykins

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Elsie L. Claudin

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X J.C. Lykins

(Address) 229 Quincy Ave. Twin Falls

15. Filed May 19 1920

John H. Cavaness
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1920, to May 16 1920, that I last saw h[illegible] alive on May 16 1920, and that death occurred on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) unknown Yrs. mos. ds.

Contributory (Secondary) Pertussis

(Duration) yrs. 2 mos. ds.

(Signed) H.H. Sawyer M. D.

2/18 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 5/18 1920

20. UNDERTAKER: J.J. Grossman — ADDRESS: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30478
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillian E Batey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept 13 (Month) (Day) 1876 (Year)

7. AGE: 44 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Perry

11. BIRTHPLACE OF FATHER (State or Country): Newyork

12. MAIDEN NAME OF MOTHER: Nat [redacted]

13. BIRTHPLACE OF MOTHER (State or Country): Newyork

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W S Batey
(Address) Kimberly

15. Filed May 19 1920 John H Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 17 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1920, to May 17 1920, that I last saw h. alive on May 17 1920, and that death occurred on the date stated above, at [redacted] M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Weaver M. D.
19 ..... (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: May 21 1920

20. UNDERTAKER: L E Hewett — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1043

(No. , St.)

File No. 30479

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harland L Pierce

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Married

6. DATE OF BIRTH: Jan 23 (Month) (Day) 1892 (Year)

7. AGE: 28 Yrs. 3 Mos. 21 ds.

IF LESS than 1 day: how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Reuben Pierce

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Sophie Corbines

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs H. L. Pierce
(Address) 6923 S. Sangamon St Chicago Ill

15. Filed May 15 1920 John F. Caughlan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29, 1920 to May 14 1920 that I last saw him alive on May 14, 1920 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary,

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. F. Passer, M. D.

May 15 1920 (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill — DATE OF BURIAL: 19

20. UNDERTAKER: L E Dewey — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30480

1. PLACE OF DEATH
County of Twin Falls
City of ..... (No. ....., ... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lasalia Adell Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: June 20 1 (Month) (Day) (Year)

7. AGE: 64 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: nurse
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Mathew Bloomer

11. BIRTHPLACE OF FATHER (State or Country): Newyork

12. MAIDEN NAME OF MOTHER: Latitia Beaniss

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Fred B. Hill
(Address): Route # 2

15. Filed May 5 1920 John F. Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 9 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 30 1920 to May 2 1920 that I last saw her alive on May 2 1920 and that death occurred on the date stated above, at 2 10 P.M.
The CAUSE OF DEATH* was as follows:

Acute Nephritis
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Cholecystitis
(Duration) 8 yrs. ..... mos. ..... ds.

(Signed) Chas. K. Scott M. D.
5-3 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho
DATE OF BURIAL: 5-5- 1920

20. UNDERTAKER: L E Trent
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30481

Registration District No. 37
Primary Registration District No. 1085

1. PLACE OF DEATH
County of Twin Falls
City of (1)
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Wegner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): S

6. DATE OF BIRTH: May (Month) 2 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: T. H. Wegner

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Mabel E Steward

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. H. Wegner
(Address) Twin Falls

15. Filed May 6 1920 John Hauschild Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to May 2nd 1920
that I last saw h.er alive on May 2nd 1920
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. L. Strand M. D.
5/4 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 5/3 1920
20. UNDERTAKER: J. J. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

No 83, 54

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30482

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls Registration District No. 37
City of " " (No. ____ St.) Primary Registration District No. 1085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William F. Taylor

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: Nov (Month) 23 (Day) 1850 (Year)

7. AGE: 70 yrs. 2 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: Taylor
11. BIRTHPLACE OF FATHER (State or Country): Ohio
12. MAIDEN NAME OF MOTHER: Elizabeth Hoshie
13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Gill
(Address) Twin Falls

15. Filed May 6 1920 John Haught Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 27 1920 to May 4 1920 that I last saw h alive on May 4 1920 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cancer of liver

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) A. O. Claudick M. D.
5/4 1920 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: May 6 1920

20. UNDERTAKER: J. P. Sorenson | ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

Dr Caughlin

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30483

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls (No. ____, ____ St.)
Registration District No. 37
Primary Registration District No. 1085

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace M. Stearns

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb 17 1870 (Month) (Day) (Year)

7. AGE: 50 yrs. 7 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Geo Day.

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Martha Da

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W J Stearns
(Address) Twin Falls Ida

15. Filed May 8 1920 John A. Caughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 1st 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h____ alive on ____ 191__, and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) John A. Caughlin M. D.
5-5 1920 (Address) Twin Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 5-5 1920

20. UNDERTAKER: C. J. Grossman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30484

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 37

County of Twin Falls Primary Registration District No. 1085

City of Twin Falls (No. 1, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Travis A Pickett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 5 (Day) 1910 (Year)

7. AGE: 9 yrs. 5 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Nyrum Pickett

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Minnie Dolman

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nyrum Pickett
(Address) Murtaugh, Idaho

15. Filed May 8 1920 John Haughey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1920 to May 2 1920, that I last saw him alive on May 2 1920, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Gun Shot wound lower Abdomen

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J R Morgan M. D.

May 7 1920 (Address) Twin Falls, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Marion Ida	May 4 1920

20. UNDERTAKER: O J Grossman ADDRESS: Twin Falls

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of ....., (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

File No. 30485

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carrie J Anson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	Married

6. DATE OF BIRTH: oct 14 (Month) 1872 (Day) (Year)

7. AGE: 48 Yrs. 6 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): on boat on mississippi River

10. NAME OF FATHER: J L Jardee

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bessie Wood
(Address) Twin Falls Ida.

15. Filed May 8 1920 John H Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: may 5 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 1920, to May 5th 1920 that I last saw her alive on May 5th 1920 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy -

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Mitral Regurgitation

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) Duncan L. Chittum M. D.

May 7 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: 5-10-1920

20. UNDERTAKER: L E Wood

ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of [illegible]

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

File No. 30480

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James M. Bowen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married

6. DATE OF BIRTH

Feb (Month) 17 (Day) 1874 (Year)

7. AGE

46 Yrs. 2 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Planter

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER T. J. Bowen

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Sarah Bell

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. A. Bower

(Address) Twin Falls

15. Filed May 14 1920 John F. Kaufman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 12:15 AM.

The CAUSE OF DEATH* was as follows:

Fractured skull and Internal Injuries received in an Automobile accident

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Goesman Coroner

5/9 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Chenoa Ill

DATE OF BURIAL ..... 19.....

20. UNDERTAKER J. J. Goesman

ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30487
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph M. Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 7 (Day) 1893 (Year)

7. AGE: 26 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Book Keeper
(b) General nature of industry, business or establishment in which employed (or employer): ——

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: J.R. Cox

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Margrette Reynolds

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) × Reynolds Cox
(Address) Twin Falls

15. Filed May 14 19 ..... John F. Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9th 1920, to May 10 1920
that I last saw h.. alive on May 10 1920
and that death occurred on the date stated above, at 9 M.
The CAUSE OF DEATH* was as follows:

Toxemia - From Drinking toilet water

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Duncan L. Brownell M. D.
5/12 1920. (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 5/14 1920

20. UNDERTAKER: J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

File No. 30489
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Robert Dana Abel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 4 (Day) 1874 (Year)

7. AGE: 46 Yrs. 2 Mos. 29 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Arkansas

10. NAME OF FATHER: Brad Abel

11. BIRTHPLACE OF FATHER (State or Country) Tenn. Ark Ramsas

12. MAIDEN NAME OF MOTHER: Nonah Walker

13. BIRTHPLACE OF MOTHER (State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R D Abel
(Address) Filer

15. Filed May 4 20 191.... A A Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29 1920 to May 3 1920.
that I last saw him alive on May 2 1920.
and that death occurred on the date stated above, at 5:45 A.M.
The CAUSE OF DEATH* was as follows:

Septicaemia
(Duration) ... Yrs. ... mos. 3 ds.
Contributory ~~(Secondary)~~ Gun shot wound
(Duration) ... Yrs. ... mos. 4 ds.
(Signed) Frank A Durig Jr. M. D.
May 3 1920. (Address) Filer, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos. 3 days. In the County Hospital State....yrs....mos. 9 days
Where was disease contracted if not at place of death? Two miles North of Filer.
Former or usual residence Filer, Idaho

19. PLACE OF BURIAL OR REMOVAL: Lea's Cemetery — DATE OF BURIAL: May 6 1920.

20. UNDERTAKER: J E Drake — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

File No. 30490
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Merlen Ham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	W.	

6. DATE OF BIRTH: Febr. (Month) 10 (Day) 1919 (Year)

7. AGE: 1 yrs. 3 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Colossburg Cala

10. NAME OF FATHER: Joseph Wm Ham

11. BIRTHPLACE OF FATHER (State or Country): North Enid Oklahoma

12. MAIDEN NAME OF MOTHER: Marchena Splain

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos. W Ham
(Address) Filer Ida

15. Filed May 21 20 191... A A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 21 20 191... (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 20 191..., to May 13 20 191..., that I last saw him alive on May 13 20 191..., and that death occurred on the date stated above, at 2 30 A. M.

The CAUSE OF DEATH* was as follows:
Occurred 10 days after
crisis in Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
19... (Address) Filer Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
I O O F Cemet	May 25 20 191...

20. UNDERTAKER	ADDRESS
J E Drake	Filer Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30491

Registered No. .....

1. PLACE OF DEATH.

County of Twin Falls

City of Filer

Registration District No. 38

Primary Registration District No. 2086

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hattie Elene Barton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 6 (Day) 1920 (Year)

7. AGE: ..... Yrs. 1 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Filer, Idaho.

10. NAME OF FATHER G. C. Barton

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Enid Pate

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) G. C. Barton

(Address) Filer Ida

15. Filed May 31 1920 A. A. Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920, to May 29 1920., that I last saw h[illegible] alive on May 29 — 1920., and that death occured on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Whooping Cough.

(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Frank A. Dwight, M. D.

May 31 1920 (Address) Filer, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I. O. O. F. Cemetery — DATE OF BURIAL: May 30 1920

20. UNDERTAKER: G. C. Barton — ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 30492
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Richard Chandler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write word.)

6. DATE OF BIRTH: Jan (Month) 31 (Day) 1902 (Year)

7. AGE: 17 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James D. Chandler.

11. BIRTHPLACE OF FATHER (State or Country): Ore.

12. MAIDEN NAME OF MOTHER: Elvira Gragg.

13. BIRTHPLACE OF MOTHER (State or Country): N. Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Chandler
(Address) Buhl Idaho

15. Filed 5-3 1920
J. T. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Gun Shot wound in Head. Suicide.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) J. F. Greenacre M.D.
5/2 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: 5/3 1920
20. UNDERTAKER: Henry & Gragg — ADDRESS: Buhl, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 30493
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lilly Worley.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Aug. (Month) 23rd. (Day) 1883 (Year)

7. AGE: 36 Yrs. 8 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon.

10. NAME OF FATHER: Kesling

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred. Worley
(Address)

15. Filed 5-4 1920 J. W. Worley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/27 1920, to 5/2 1920, that I last saw h.e alive on 5/1 1920, and that death occurred on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows:
General Septicaemia following Confinement
Puerperal Fever place 4/24/20
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. B. McCluskey M. D.
5/3 1920 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida | DATE OF BURIAL: 5/4 1920

20. UNDERTAKER: Hanna B Evans | ADDRESS: Burley

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

1. PLACE OF DEATH
County of Twin Falls
City of Burley
If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH
Registration District No. 39
Primary Registration District No. 2087
(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30494
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willie F. Popp.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 6 (Day) 1888 (Year)

7. AGE: 32 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: August Popp

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Ernestine Jann

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Kate Popp
(Address) .....

15. Filed 5-6 1920. J. A. Murphy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h... alive on ..... 191....
and that death occurred on the date stated above, at ....., ...M.
The CAUSE OF DEATH* was as follows:
Suicide by Hanging
..... (Duration) ..... Yrs..... mos..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs..... mos..... ds.
(Signed) J. Grossman Coroner
May 3 1920 (Address) Twin Falls
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley — DATE OF BURIAL: 5/9 1920

20. UNDERTAKER: Homer B. Evans — ADDRESS: Burley

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2081
File No. 30495
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John F. Haley.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March 16 (Month) (Day) 1859 (Year)

7. AGE: 61 Yrs. 1 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ark.

10. NAME OF FATHER: not known Haley -

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Haley
(Address) Buhl Ida

15. Filed 5-8 1920
Buhl Ida
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2. 1920, to May 7 1920, that I last saw h.m. alive on May 7 1920, and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Gangrene lung
(Duration) Yrs. mos. ds.
Contributory (Secondary) Flu 1 week ago
(Duration) Yrs. mos. ds.

(Signed) A. Thackeray M. D.
5/7 1920 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: 5/9 1920

20. UNDERTAKER: Manville D. Rugg — ADDRESS: Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30496
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39
Primary Registration District No. 7087
(No. ....., ... St.)

2. FULL NAME Edith C. Hagar.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH. Sept (Month) 23rd (Day) 1 (Year)

7. AGE: 22 Yrs. 7 Mos. 16 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Chas W. Clark

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Carrie B. Shiefman

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. M. Hagar
(Address):

15. Filed May 11 1920. J. H. Murphy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-7- 1920 to 5-9- 1920 that I last saw h.er alive on 5-9- 1920 and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) George Jennings M. D.

5-10 1920 (Address) Burke, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: 5/11/ 1920

20. UNDERTAKER: Homer B Evans ADDRESS: Burke

Information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS CONFORMING INK—THIS IS A PERMANENT RECORD.
state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 7087
File No. 30498
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of Burley
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucy A. Schuler.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH. Dec 29 1850
(Month) (Day) (Year)

7. AGE 70 Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER Mr Taylor

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Leah Shaybaugh

13. BIRTHPLACE OF MOTHER (State or Country) Penna.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ella M. Newbrough
(Address) Burley

15. Filed May 12 191....
J. N. Murphy
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/12 1920 to 5/12 1920
that I last saw h.. alive on 5/11 1920
and that death occurred on the date stated above, at 3 A M.

The CAUSE OF DEATH* was as follows:
Carcinoma of
Sigmoid portion
of Colon
(Duration) 2 Yrs. 4 mos. 1 ds.

Contributory (Secondary) Uncertain
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) A. Hayden M. D.
5/12 1920 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Roann Indiana — DATE OF BURIAL ..... 191...

20. UNDERTAKER Homer B. Evans — ADDRESS Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of Burke.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39
Primary Registration District No. 2087
(No. ..... St.)

File No. 30501
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rachael Ann Lowery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Sept (Month) 28 (Day) 1913 (Year)

7. AGE: 6 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: C. A. Lowery

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Daisy Foster

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Lowery
(Address) Burke Ida

15. Filed 5-24 1920 J. A. Merkley Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Freeman Coroner
5/23 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burke Ida
DATE OF BURIAL: 5/25 1920

20. UNDERTAKER: Homer B Evans
ADDRESS: Burke

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2084
File No. 30502
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. J. Worley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1832 (Year)

7. AGE: 88 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Dont Know.

11. BIRTHPLACE OF FATHER (State or Country): Dont Know.

12. MAIDEN NAME OF MOTHER: Dont Know.

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas H Worley
(Address)

15. Filed 5-1 1920 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19.. to ..... 19.., that I last saw h.. alive on April 28 1920, and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
(Duration) 2 Yrs. X mos. ds.
Contributory (Secondary)
(Duration) X yrs. mos. ds.
(Signed) J. H. Murphy M. D.
4/30 1920 (Address) Burke Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Ida
DATE OF BURIAL: May 1 1920

20. UNDERTAKER: Homer B Evans
ADDRESS: Burke

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics'
File No. 30503
Registered No.

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adrienne Jane Mrs Frederick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	White	married

6. DATE OF BIRTH: February 15th 1880 (Month) (Day) (Year)

7. AGE: 39 Yrs. 2 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ogden Utah

10. NAME OF FATHER: Joseph Riddle

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Adrienne Jane Freefield

13. BIRTHPLACE OF MOTHER (State or Country): Springfield Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address)

15. Filed 6/10 1920 Leola Nodding Deputy. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 20th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 10 1920, to Apr 20 1920, that I last saw h[illegible] alive on Apr 20 1920 and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:

[illegible]
Cirrhosis of Liver
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas F. Hammer M. D.
4/23/ 1920 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 3 days. In the State Life time yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ..... Yes
Former or usual residence Cottonwood Ida Co

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 4-23 1920

20. UNDERTAKER: W C Doelle — ADDRESS: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
(No. ..... St.)

File No. 30504
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Albina Blake
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 17th (Month) (Day) 1850 (Year)

7. AGE: 69 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Isa Poulley

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Stella M. Cosper
(Address) Seattle, Wash.

15. Filed 6/10 1920 Leola Noddings Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
April 14" (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 1 1920, to Apr 13 1920, that I last saw her alive on Apr 13 1920, and that death occured on the date stated above, at 9 Am M.

The CAUSE OF DEATH* was as follows:
Abscess on appendix operation refused

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas F. Hammel M. D.
4/13 1920 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Cemetery — DATE OF BURIAL: 4-16" 1920

20. UNDERTAKER: Wm C. Joeble — ADDRESS: Moscow Ida

B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 30505
Registered No. ....

1. PLACE OF DEATH.
County of Lewis
City of Salmon
(No. ...., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James E. Hemphill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Oct 22nd (Month) (Day) 1848 (Year)
7. AGE: 71 Yrs. 3 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... (Day Laborer Farming)
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) New York
10. NAME OF FATHER Robert Hemphill
11. BIRTHPLACE OF FATHER (State or Country) Not known
12. MAIDEN NAME OF MOTHER Cirilda Babcock
13. BIRTHPLACE OF MOTHER (State or Country) New York
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Ophelia Hemphill
(Address) Salmon Idaho
15. Filed 6/10 1920 Leola Noddings Deputy Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH January 29th 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1919, to Jan 29 1920, that I last saw h[illegible] alive on Jan 29 1920, and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) Yrs. 3 mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Chas. F. Hammer M. D.
1/31 1920 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 1-30 1920
20. UNDERTAKER: Wm C Jacobs — ADDRESS: Salmon Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

File No. 30506
Registered No. .....

1. PLACE OF DEATH.
County of Lemhi
City of Lemhi
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lora M Lahmeyer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 21 (Day) 1886 (Year)

7. AGE: 73 Yrs. 5 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Simeon Benedict

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Elsa Robinson

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. S. Lahmeyer
(Address) Salmon Idaho

15. Filed 6/10 1920 Leola Nodding Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Mar (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 2 1920, to Mar 2 1920, that I last saw h[illegible] alive on Mar 2 1920, and that death occured on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Hammon M. D.
Mar 9 1920 (Address) Salmon

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 3-6" 1920

20. UNDERTAKER: Wm C Doubles — ADDRESS: Salmon Idaho

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-23

CERTIFICATE OF DEATH.

Registration District No. 41

Primary Registration District No. 2116

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30507

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

If death occurs away from usual residence, give facts called for under special information. County Farm

2. FULL NAME Ezery Orr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 6th (Month) (Day) 1818 (Year)

7. AGE: 101 Yrs. 10 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. (None) County Farm
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Burrell Brangy

(Address) Salmon Idaho

15. Filed 6/10 1920

Leola Rodeling Deputy. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb 19th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1919, to Feb 19 1920, that I last saw h..... alive on Feb 19 1920, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

General debility
Following bronchio-
pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Hammer M. D.

Feb 19 1920 (Address) Salmon Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery

DATE OF BURIAL: 2-20" 1920

20. UNDERTAKER: W C Doebele

ADDRESS: Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 45
Primary Registration District No.
(No. ..... St.)

File No. 30508
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of Spirit Lake, Ida.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry J. Fitz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. July (Month) 31 (Day) 1914 (Year)

7. AGE: 5 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Spirit Lake, Ida. Kootenai Co

10. NAME OF FATHER Harry Fitz

11. BIRTHPLACE OF FATHER (State or Country) Buffalo N.Y

12. MAIDEN NAME OF MOTHER Ray Green

13. BIRTHPLACE OF MOTHER (State or Country) Magnota Sa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. H. Fitz
(Address) Spir. Lake.

15.
Filed ..... 191.....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 3rd 1920 to Feb 17th 1920, that I last saw h[illegible] alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Double lobar pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Cold -
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Earle O Priddy M. D.
19..... (Address) Spir Lake Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: U.S. Lake Cem — DATE OF BURIAL: 2/19 1920

20. UNDERTAKER: O. W. Stone — ADDRESS: Rathdrum

SYMS - YORK CO., PTRS. & BOOKS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30509

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Spirit Lake, Ida.

Registration District No. 405

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvester Nelson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 11 (Day) 1857 (Year)

7. AGE: 62 Yrs. 11 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mill Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Burras W. Nelson

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Nancy Marsh

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Laura Nelson

(Address) Athol Ida

15. Filed 5/20 1920 [signature] Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1919, to May 28 1920, that I last saw him alive on May 18 1920, and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) several Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Emil Hoyer M. D.

19..... (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Peone Prairie | DATE OF BURIAL: May 20 1920

20. UNDERTAKER: C. W. Stone | ADDRESS: Pathdrum Ida

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30510

Registered No. .....

1. PLACE OF DEATH.

County of Idaho

City of Harrisburg

Registration District No. 49

Primary Registration District No. 2428

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Foot

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March 7 1851
(Month) (Day) (Year)

7. AGE: 69 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Isaac King

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rebecca Yoder

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E A Foot
(Address) Yaquina Oregon

15. Filed 5/19 1920 D J Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 18 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1920, to alone 191..., that I last saw h.s.a. alive on May 16th 1920, and that death occured on the date stated above, at 7 p.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Mitral insufficiency

(Duration) Never Under Yrs. ..... mos. ..... ds.

(Signed) J. A. Burgess M. D.

5/19 1920 (Address) Harrisburg Oreg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodland Cem. DATE OF BURIAL: 5/19 1920

20. UNDERTAKER: D J Johnson ADDRESS: 5/19/20

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNR. 24656

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 49

Primary Registration District No. 2428

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30511

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Ben Kamiah

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adair Hausche

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Divorced

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 887 (Year)

7. AGE about 34 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Joseph Hausche

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Julia Williams

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert Parsons

(Address) Kamiah Ida

15. Filed 5/18 1920

C J Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 18th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12th 1920, to ..... 191..., that I last saw him alive on 15th May 1920, and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows

Lobar Pneumonia

.....

.....

.....(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. J. Brosnan M. D.

5/18 1920. (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind. Cem. No 1, Kamiah Ida — DATE OF BURIAL: 5/21 1920

20. UNDERTAKER C J Johnson — ADDRESS Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2428
(No. ..... St.)
File No. 30512
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Near Kamiah Ida
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred L. Skinner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Feb (Month) 1 (Day) 1854 (Year)
7. AGE: 66 Yrs. 3 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Nova Scotia
10. NAME OF FATHER: Henry Skinner
11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia
12. MAIDEN NAME OF MOTHER: Ruth Illsley
13. BIRTHPLACE OF MOTHER (State or Country): ?
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Skinner
(Address) Kamiah Ida RFD
15. Filed 5/15 1920 C. J. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1919, to about 191, that I last saw h— alive on April 191, and that death occured on the date stated above, at 9.30 A.M.
The CAUSE OF DEATH* was as follows:
Coronary Arbit.
(Duration) 4 Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) C. H. Bryan M. D.
5/14 1920 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn Hill Cem. Idaho C. Ida. DATE OF BURIAL: 5/17 1920
20. UNDERTAKER: C. J. Johnson ADDRESS: Kamiah Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYRO - YORK CO., PTRS. & SMRS. 24858

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2428
(No. ..... St.)

File No. 30513
Registered No. .....

1. PLACE OF DEATH.

County of Lewis
City of Kamiah

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Liggie Harper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. May (Month) 28 (Day) 1843 (Year)

7. AGE: 77 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Daniel Durst

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Mary McKeesmer

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Alice M. Sparr
(Address) Kamiah Idaho

15. Filed 5/28 1920 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1920, to March 1920, that I last saw her alive on April 1920, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis Heart Disease

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) C. F. Bryan M. D.
5/28/1920 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dog Town Cem. Kamiah Idaho — DATE OF BURIAL: 5/28 1920

20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STYER - YORK CO., PTRS. & BKBS. 24958

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2428
(No. ..... St.)
File No. 30514
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Near Kamiah
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm L Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BI

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: Whit
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 31 (Day) 1861 (Year)

7. AGE: 58 Yrs. 9 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Henry Moore

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Rosanna Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wesley J. Moore
(Address) Kamiah

15. Filed 5/31 1920
C J Johnson
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sudden death 191..., to Sudden death 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Acute Heart failure

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Mitral Insufficiency
(Duration) ? yrs. ..... mos. ..... ds.
(Signed) A. A. Bryan M. D.
5/31 1920 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Spokane Wash
DATE OF BURIAL ..... 191...

20. UNDERTAKER: C J Johnson
ADDRESS Kamiah Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Payette
City of Fruitland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2130
Primary Registration District No.
(No. , St.)

File No. 30515
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John McPherson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Dec (Month) 25 (Day) 1840 (Year)

7. AGE: 79 Yrs. 4 Mos. 8 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Donald McPherson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Katherine McDermot

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Kate McPherson
(Address) R. F. D. No. 1. Payette, Ida.

15. Filed May 3, 1920 — E. C. Paxton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1920 to May 3 1920 that I last saw h[illegible] alive on [illegible] 19[illegible] and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH was as follows:

apoplexy

(Duration) a few minutes — Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E. C. Paxton M. D.
5/3 1920 (Address) Fruitland

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette — DATE OF BURIAL: 5-5 1920

20. UNDERTAKER: J. H. Adair — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 30616
Registered No.

1. PLACE OF DEATH
County of Boyce
City of Fruitland
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Lawrence Hurd
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 13 (Day) 1920 (Year)

7. AGE: X Yrs. X Mos. 27 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Fruitland Idaho

10. NAME OF FATHER: Earl Hurd

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Marian Arment

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edith Landon
(Address) Payette Idaho

15. Filed May 11 1920 C C Gaylord Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1920, to May 9 1920, that I last saw him alive on May 7 1920, and that death occurred on the date stated above, at 5:00 P.M.
The CAUSE OF DEATH* was as follows:
Marasmus

(Duration) Yrs. mos. 20 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) O. H. Avery M. D.
May 11, 1920 (Address) Payette, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: May 10 1920
20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
(No. ..... St.)

File No. 30517
Registered No. .....

1. PLACE OF DEATH.
County of Bear Lake
City of Ovid
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gertrude M King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Feb (Month) 2 (Day) 1870 (Year)
7. AGE: 50 Yrs. 2 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: Lars Peter Sorenson
11. BIRTHPLACE OF FATHER (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Martha Christiana Mortensen
13. BIRTHPLACE OF MOTHER (State or Country): Denmark
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Elgin King
(Address) Ovid Idaho
15. Filed May 1 1920
E. D. King
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 30 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Apr 3 1920 to Apr. 23 1920, that I last saw h.. alive on Apr 23 1920 and that death occured on the date stated above, at 9:30 A. M.
The CAUSE OF DEATH* was as follows:
Influenza (Relapse from)
(Duration) Yrs. 2 mos. 10 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. O. Moore M. D.
May 3 1920 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ovid Idy. DATE OF BURIAL: May 3 1920
20. UNDERTAKER: Bishop Lindsay, ADDRESS: Ovid Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2136
File No. 30518
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katrine May Young
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March 7th 1920
(Month) (Day) (Year)

7. AGE: Yrs. 1 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Woodboro Idaho.

10. NAME OF FATHER: Edgar M Young.

11. BIRTHPLACE OF FATHER (State or Country): Married Mo Apr 20 1920

12. MAIDEN NAME OF MOTHER: Ida K. Parker

13. BIRTHPLACE OF MOTHER (State or Country): Lanark Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Edgar M. Young
(Address): Montpelier Idaho

15. Filed 5-3-1920 N. H. Berry
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 30th 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 13 1920 to April 30 1920, that I last saw h... alive on ..... 19....., and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Whooping Cough.

(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) A. D. Ashley M. D.

(Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lanark Idaho. DATE OF BURIAL: May 2 1920.

20. UNDERTAKER: Nichols Parker ADDRESS: Lanark

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30519

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52

Primary Registration District No. 2136

(No. ....., ... St.)

2. FULL NAME Alice Ann Hayes

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 11 (Day) 1884 (Year)

7. AGE: 35 Yrs. 9 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Henry Roberts

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Ward

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Thos. Hayes

(Address) Georgetown, Idaho

15. Filed 5-8-1920

N. H. Kemp
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-1 1920 to 4-4 1920 that I last saw h... alive on 4-4 1920 and that death occured on the date stated above, at 1 30 P.M.

The CAUSE OF DEATH* was as follows: Puerperal Fever

Edward Bentley

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) Thos. Bentley M. D.

4-5 1920 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Georgetown, Idaho | DATE OF BURIAL: Apr 7 1920

20. UNDERTAKER: F. M. Williams | ADDRESS: Montpelier

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5-2
Primary Registration District No. 2136
(No. ....., ... St.)
File No. 30526
Registered No. .....

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Beckwith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Mar (Month) 22 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Edw. J. Beckwith

11. BIRTHPLACE OF FATHER (State or Country) Wyoming

12. MAIDEN NAME OF MOTHER Stend. Rohner

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Edward J. Beckwith
(Address) Montpelier Idaho

15. Filed 5-3- 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-22 1920, to 3-31 1920, that I last saw him alive on 3-29 1920, and that death occured on the date stated above, at 1:30 M.
The CAUSE OF DEATH* was as follows: - Prematurity
Baby was about 6 Wk Premature
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
Duration ..... yrs. ..... mos. ..... ds.
(Signed) Dr. C. Cubley M. D.
3-31 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier, Idaho — DATE OF BURIAL: Jan 31 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 52

Primary Registration District No. 2,36

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30521

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Claud Clifton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 8. (Day) 1917 (Year)

7. AGE: 2 Yrs. 10 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Child.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Wm Clifton

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Libbie Hill

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm Clifton

(Address) Montpelier Idaho.

15. Filed 5-31- 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 30th 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28th 1920, to March 30th 1920., that I last saw h.... alive on March 30th 1920, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

..... (Duration) — Yrs. 1 mos. — ds.

Contributory (Secondary) Meningitis

..... (Duration ..... yrs. ..... mos. 3 ds.

(Signed) Elmer C. Hinckley M. D.

4-1-1920 (Address) Montpelier, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St Charles Idaho. DATE OF BURIAL: Apr. 1 1920

20. UNDERTAKER: J. M. Williams ADDRESS: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BORS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ben Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 30522
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Phelps.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Infant

6. DATE OF BIRTH
Mar 19 1920
(Month) (Day) (Year)

7. AGE
..... yrs. ..... mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo Phelps,

11. BIRTHPLACE OF FATHER (State or Country) W.S.A.

12. MAIDEN NAME OF MOTHER ,

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F McWilliams
(Address) Montpelier

15.
Filed 5-3- 1920 A N Kinney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
March 27th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 19 1920 to March 27 1920, that I last saw him alive on March 27 1920, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Gastro intestinal hemorrhage

(Duration) ~ yrs. ~ mos. 8 ds.

Contributory (Secondary) ~

(Duration) ~ yrs. ~ mos. ~ ds.

(Signed) Elmer E. Hickley M. D.
4/12 1920, (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Montpelier. DATE OF BURIAL March 28 1920

20. UNDERTAKER F. M. Williams ADDRESS Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 30523
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rebekah Obrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: 3 (Month) 2 (Day) 1838 (Year)

7. AGE: 82 yrs. — mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work (Invalid) no occupation
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER James Skinner

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Rebekah Wolf

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Obrey
(Address) Idaho Falls Idaho

15. Filed 5-31-1920 N. N. Keys Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 3 (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Physician 191..., to No Physician 191..., that I last saw her alive on Mch 14 1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) — yrs. — mos. — ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) No Physician M. D.

19.... (Address) N. N. Keys Registrar

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida | DATE OF BURIAL: Mch 17th 1920

20. UNDERTAKER: H. H. Williams | ADDRESS: Montpelier Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ..... St.)

File No. 30524
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Horten Hansen

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. ~~SINGLE~~, MARRIED, WIDOWED OR ~~DIVORCED~~. (*Write* the word.): Infant

6. DATE OF BIRTH: 1 (Month) 2 (Day) 1920 (Year)

7. AGE: — yrs. 1 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.? —

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country): Montpelier Ida.

10. NAME OF FATHER: Horten Hansen

11. BIRTHPLACE OF FATHER (State or Country): U. S.

12. MAIDEN NAME OF MOTHER: Lottie Daylon

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [signature]
(Address) Montpelier Ida

15. Filed 5-3, 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 2 (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191..., that I last saw h... alive on ... 191..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Whooping Cough
(Duration) 3 yrs. ... mos. ... ds.
Contributory (Secondary) —
(Duration) — yrs. ... mos. ... ds.

(Signed) [signature] M. D.
2-12 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida
DATE OF BURIAL: Feby 15 1920

20. UNDERTAKER: [illegible] F. M. Williams
ADDRESS: [illegible] Montpelier

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 52

Primary Registration District No. 2136

File No. 30525

Registered No.

County of Bear Lake

City of Bennington Ida (No. ; St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME ~~William Hugh Hume~~ Hugh Hume

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH

11 (Month) 30 (Day) 1883 (Year)

7. AGE

36 yrs. 2 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): U. S.

10. NAME OF FATHER: David P. Hume

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary Hughes

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Wright

(Address) Bennington Ida

15.

Filed 5-1- 1920

J. H. Kemp
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

2 (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-1 1920 to 2-6 1920, that I last saw h~~e~~ alive on 2-4 1920 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows: Nephritis

Bright's Disease

(Duration) 9 yrs. mos. ds.

Contributory (Secondary) Influenza

(Duration) yrs. mos. ds.

(Signed) Gus F Cudaby M. D.

2-7 1920 (Address) Bennington

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bennington Ida — DATE OF BURIAL: Feby 8 1920

20. UNDERTAKER: J. M. Williams — ADDRESS: Montpelier Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier Ida.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 30526
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Ann Bunney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
5 (Month) 5 (Day) 1830 (Year)

7. AGE
89 yrs. 11 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.? —

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John Mallet

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Perkins Sr
(Address) Montpelier Idaho

15.
Filed 5-3, 1920 A. K. King Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
5 (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from No physician 191.., to — 191..., that I last saw h— alive on — 191..., and that death occurred on the date stated above, at 10:25 P.M.

The CAUSE OF DEATH* was as follows:
Senility

(Duration) 5 yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) — yrs. — mos. — ds.

(Signed) E. H. Gueyon M. D.
5-1 1920 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? —
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida — DATE OF BURIAL: May 4 1920

20. UNDERTAKER: Evans & Williams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine.
City of Hailey.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022
(No. ....., ... St.)

File No. 30527
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella R. Boyd.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Aug. (Month) 18. (Day) 1871. (Year)

7. AGE: 48 yrs. 8 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Seamstress.

9. BIRTHPLACE (State or Country) Wisconsin.

10. NAME OF FATHER Thomas Walker.

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Mary Gavin.

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. I. Fitzmiller
(Address) Vancouver, Wash.

15. Filed June 1 1920 R. A. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May. (Month) 1 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan-22 1920 to Apr. 30 1920
that I last saw h.r alive on Apr. 30 1920
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Brights Disease
I know
(Duration) Don't yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert A. Wright M. D.
5/2 1920 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey Idaho — DATE OF BURIAL: 5/3 1920

20. UNDERTAKER: J. D. Harris — ADDRESS: Hailey

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine.
City of Near Gannett.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022
(No. ..... St.)

File No. 30528
Registered No. 22
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John J Coveney.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White.	Single

6. DATE OF BIRTH
..... (Month) 1 (Day) ..... (Year)

7. AGE about. 73 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland.

10. NAME OF FATHER "

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed June 1 1920 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

Dutton.

16. DATE OF DEATH May 1st, 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to May 1 1920,
that I last saw him alive on May 1 1920,
and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Exhaustion
Not known how long
Dr. Saw him 10 min. before death
..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H H Dutton M. D.
May 3 1920 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bellevue	5/3 1920

20. UNDERTAKER	ADDRESS
R. B. Harris	Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30529
Registered No. 24

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Blaine
City of Hailey
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022
(No. ....., ... St.)

2. FULL NAME Jno Robert McDonald Wright.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced

6. DATE OF BIRTH: July 29 1856
(Month) (Day) (Year)

7. AGE: 69 yrs. 9 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia.

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) † Catherine Fraser
(Address) Hailey Idaho

15. Filed June 1 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 8th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920 to May 8th 1920
that I last saw h im alive on May 7 1920
and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) Don't Know yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.
5/9 1920 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey Ida — DATE OF BURIAL: 5/10 1920

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30530

Registered No. 23

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine

City of Carey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21

Primary Registration District No. 2075

(No. ..... , ... St.)

2. FULL NAME Charles Elmer Brooks.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 1 (Day) 1918 (Year)

7. AGE: 2 Yrs. 4 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Blaine Co. Idaho

10. NAME OF FATHER: Elmer J. Brooks

11. BIRTHPLACE OF FATHER (State or Country): Carey.

12. MAIDEN NAME OF MOTHER: Rose Albertson

13. BIRTHPLACE OF MOTHER (State or Country): Blaine Co. Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. H. L. Richards.
(Address) Carey Idaho.

15. Filed 5-15 1920 R. H. Wright Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 26 1920, to May 1 1920, that I last saw h-- alive on May 1 1920 and that death occured on the date stated above, at 1:10 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
from injury

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary): none

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Houston E. Snyder M. D.

5/4 1920 (Address) Carey Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Carey Idaho. DATE OF BURIAL: 5-4 1920

20. UNDERTAKER: R. D. Harris ADDRESS: Hailey

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
File No. 30532
Registered No. 26

1. PLACE OF DEATH.
County of Blaine
City of Bellevue (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Silas G. Falls

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W-White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dont Know (Month) (Day) 1851. (Year)

7. AGE: 69 yrs. ~ mos. ~ ds.
IF LESS than 1 day how many ..... hrs. or ~ mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): Self

9. BIRTHPLACE (State or Country): Portland Co. Iowa

10. NAME OF FATHER: Robinson Falls

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Eliza Anne Holcomb

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nourida Williams
(Address) Bellevue Idaho

15. Filed June 6, 1920 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/20 1920 to 6/30 1920 that I last saw h[illegible] alive on 5/30 1920 and that death occurred on the date stated above, at 12 30 P. M.

The CAUSE OF DEATH* was as follows:
Rocky Mountain Spotted (Tick) Fever.

(Duration) ..... yrs. ..... mos. 10 ds.
Contributory Pricardidis*
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. J. Moir M. D.
5/31 1920 (Address) Bellevue

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bellevue, Ida — DATE OF BURIAL: June 2 1920

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58 d
Primary Registration District No. 2138
File No. 30533
Registered No.

1. **PLACE OF DEATH**
County of Camas
City of Soldier
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** No Name (— Peck)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. **DATE OF BIRTH** May (Month) 30 (Day) 1920 (Year)

7. **AGE** ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 10 min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Soldier, Idaho.

10. **NAME OF FATHER** William H. Peck

11. **BIRTHPLACE OF FATHER** (State or Country) Idaho.

12. **MAIDEN NAME OF MOTHER** Lavina Elizabeth Lambeth

13. **BIRTHPLACE OF MOTHER** (State or Country) Idaho.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs W N Peck
(Address) Soldier, Idaho

15. Filed June 10 1920 — L Wellencheck, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** May (Month) 30 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** May 30 1920, to May 30 1920
that I last saw h.im alive on May 30 1920,
and that death occurred on the date stated above, at 11:50 P.M.
The CAUSE OF DEATH* was as follows:

Premature Birth (7 months gestation)

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Wellencheck M. D.
June 10 1920 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 19 .....
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 284
Primary Registration District No. 2138
File No. 30534
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Mayland (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Bunn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: Jan (Month) 22 (Day) 1897 (Year)

7. AGE: 23 Yrs. 3 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Jas F Bunn

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Manetta King

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Parley S. Lewis
(Address): Fairfield, Idaho

15. Filed June 10 1920 L Wilencheck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5 1920, to May 11 1920, that I last saw h[im] alive on May 11 1920, and that death occurred on the date stated above, at 10A M.
The CAUSE OF DEATH* was as follows:

Intestinal obstruction following Kick by horse in abdomen

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Wilencheck M. D.
June 10 1920 (Address) Fairfield Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	May 1 19 20
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 59
Primary Registration District No. 2129
(No. ....., ... St.)

File No. 30535
Registered No. .....

1. PLACE OF DEATH.
County of Butte
City of Arco
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Clyde Samworth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 9 (Day) 1907 (Year)

7. AGE: 13 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Arco, Ida

10. NAME OF FATHER: Joseph Samworth

11. BIRTHPLACE OF FATHER (State or Country): Colo

12. MAIDEN NAME OF MOTHER: Flora Long

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Orson Williams
(Address) Arco Ida

15. Filed 5-14 191[illegible]
Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1920, to May 13 1920, that I last saw h[illegible] alive on May 13 1920, and that death occured on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(Duration) 6 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Cannon M. D.
May 16 1920 (Address) Arco, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Arco, Ida — DATE OF BURIAL: 5-14-1920

20. UNDERTAKER: O. Williams — ADDRESS: Arco Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... St.)

File No. 30536
Registered No. 100

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Malon Nestower

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: May (Month) 10 (Day) 1836 (Year)

7. AGE: 84 Yrs. ... Mos. 1 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Not Known Here

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Van W. Nestower
(Address): Moscow

15. Filed 5/11 19... W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1920 to May 11 1920, that I last saw h... alive on May 11 1920, and that death occurred on the date stated above, at 3:50 P.M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) old age
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Clarke M. D.
5/11 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 5/13 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 30537
Registered No.

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosa Thompson,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH: Jan (Month) 25 (Day) 1877 (Year)

7. AGE: 43 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Gotlieb Blaser

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Not Known Here

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Thompson
(Address) Galata Mont.

15. Filed 5/13 1920 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1920, to [redacted] 12 — 1920, that I last saw h[redacted] alive on May 12 — 1920, and that death occurred on the date stated above, at 4:10 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of the Rt. Breast

(Duration) 1 Yrs. 5 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Willis M. D.
May 14 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 5/14 1920

20. UNDERTAKER: Glen Tuttle — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30538

Registered No. 101

Registration District No. 61

Primary Registration District No. 1011

1. PLACE OF DEATH

County of Latah

City of Moscow

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Staton,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec 8 1855
(Month) (Day) (Year)

7. AGE: 64 Yrs. 5 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: — Staton

11. BIRTHPLACE OF FATHER (State or Country): Not Known here

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rebecka Staton
(Address) Moscow

15. Filed May 26 1920 W.H. Carithers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 25 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 12 1920 to May 25 1920 that I last saw him alive on May 25 1920 and that death occurred on the date stated above, at 1 a M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) Yrs. 1½ mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.W. Stevenson M. D.

5/26 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 5/27 1920

20. UNDERTAKER: [illegible] — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Troy
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 64
Primary Registration District No. 2144
(No. ....., ... St.)

File No. 30539
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Huldah Spencer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Femal	White	Widow

6. DATE OF BIRTH
January (Month) 30 (Day) 1853 (Year)

7. AGE
67 yrs. 2 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... House wife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ellen Holtz
(Address) Troy, Idaho

15.
Filed apr 10 1920 J E Pickard
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
April (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 10 1920, to April 8 1920, that I last saw her alive on April 8 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease.
(Duration) 4 yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J M McCaa M. D.
Apr 10 1920 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ilo Ida	apr 12 1920
20. UNDERTAKER	ADDRESS
J E Pickard	Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Garfield wash. P.O.

Registration District No. 65
Primary Registration District No. 2145
(No. ....., ... St.)

File No. 30540
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Anna Rogers

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 30 (Day) 1868 (Year)

7. AGE: 51 yrs. 4 mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Joseph Hutcheson

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cintha E dwards
(Address) Garfield, Wash

15.
Filed May 31 1920 J. W. Thompson per F L Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920, to May 28 1920
that I last saw h..... alive on May 26 1920
and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
May 28 19..... (Address) Elmira

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane, wash.
DATE OF BURIAL: May 31 1920

20. UNDERTAKER: F. L. Swim
ADDRESS: Garfield Wa

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
File No. 30541
Registered No.

1. PLACE OF DEATH
County of Latah
City of Potlatch
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Ragena Farson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) 5 (Day) 1920 (Year)

7. AGE: — Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Bayard T. Farson

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Gertrude S. Anshutz

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bayard T. Farson
(Address) Potlatch, Idaho

15. Filed May 15 1920 J. W. Thompson per GL Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1920, to May 14 1920 that I last saw h. alive on May 14 1920, and that death occurred on the date stated above, at 12 05 P.M.
The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Paul J. Ferris M. D.
May 14 1920 (Address) Potlatch, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. 2 mos. 9 days. In the State — yrs. 2 mos. 9 days
Where was disease contracted if not at place of death? —
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Rocks Creek Cemetery — DATE OF BURIAL: May 15 1920

20. UNDERTAKER: Parents — ADDRESS: Potlatch, Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30542
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Harvard
(No. ....., ... St.)
Registration District No. 65
Primary Registration District No. 2145
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward A Butt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Sept (Month) 22 (Day) 1854 (Year)

7. AGE
65 Yrs. 3 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs E A. Butt
(Address) Harvard Ida

15.
Filed May 31 1920
J. W. Thompson Local Registrar
per PJ

BYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1920 to May 21 1920
that I last saw him at 5 a.m. alive on May 21 1920
and that death occured on the date stated above, at about noon M.

The CAUSE OF DEATH* was as follows:
Apoplexy with Hemiplegia

(Duration) about yrs. 17 hours mos. ds.
Contributory (Secondary) Organic Heart Disease
(Duration several yrs. mos. ds.

(Signed) W. S. Darth M. D.
5-21-1920 (Address) Palouse Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: L. M. Irwin
DATE OF BURIAL ..... 191...

20. UNDERTAKER: Coeur d'Alene Ida
ADDRESS: Palouse

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 65

Primary Registration District No. 2145

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30543

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Howard

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry E Warfield

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 24 (Day) 1888 (Year)

7. AGE: 32 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa Hoate

10. NAME OF FATHER: William Hoate

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Olive Sweet

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Olive Moats

(Address) Irving Wash

15. Filed June 4 1920 J. W. Thompson Local Registrar per ....

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1920, to June 7 1920, that I last saw h[illegible] alive on June 7 1920, and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Blood poisoning

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Parr M. D.

19..... (Address) Potlatch Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pullman Wash — DATE OF BURIAL: June 5 1920

20. UNDERTAKER: L. M. Irwin — ADDRESS: Palouse

SYMS - YORK CO., PTRS. & SAMS. 24954

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 930544

Registered No.

Registration District No. 66

Primary Registration District No. 2146

1. PLACE OF DEATH

County of Latah

City of Bovill

(No. Bovill Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm A Dubourn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Not Known (Month) (Day) 1 (Year)

7. AGE: 54 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Black Smith

(b) General nature of industry, business or establishment in which employed (or employer): Lumber Camp

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) —

(Address) —

15. Filed May 7 1920

W. C. Gibson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 7th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1920, to May 7 1920 that I last saw h sick alive on May 7 1920 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Crushing injury of Right thigh. Accidental

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. C. Gibson M. D.

19 (Address) Bovill Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse Wn. DATE OF BURIAL 19

20. UNDERTAKER: E. M. Irwin ADDRESS: Palouse Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 180545

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Bovill Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 66

Primary Registration District No. 2146

(No. Bovill Hospital St.)

2. FULL NAME Leona M. Queener

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE W White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Sept. (Month) 11 (Day) 1884 (Year)

7. AGE 35 Yrs. 8 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER Trobridge

13. BIRTHPLACE OF MOTHER (State or Country) America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) T. P. Queener

(Address) Harrard

15. Filed 5/20/1920

Mrs. F. C. Gibson
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 – 1920, to May 20 1920, that I last saw her alive on May 20 – 1920, and that death occured on the date stated above, at 5 – A. M.

The CAUSE OF DEATH* was as follows:

Embolism

Septic ~~Embolism~~ of left lung

.....(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Septic Abortion

.....(Duration ..... yrs. ..... mos. 16 ds.

5/20/1920 (Signed) F. C. Gibson M. D.

(Address) Bovill Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 10 days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Harrard

DATE OF BURIAL .....191.....

20. UNDERTAKER E. M. Irwin

ADDRESS Potlatch Idaho

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Nez Perce
City of Lapwai

Registration District No. 68
Primary Registration District No.
(No. , St.)

File No. 30546
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Aaron Jackson Wells

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb 4th. (Month) (Day) 1834 (Year)

7. AGE: 86 yrs. 3 mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Wells

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not none

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J Baker Wife
(Address) Lapwai

15. Filed May 9 1920 R. H. Pepple Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 9 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5th 1920, to May 7 1920 that I last saw him alive on May 7 1920, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Conflecantion of bladder

(Duration) Do not know yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Mrs J Baker M. D.
19 (Address) Lapwai

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lapwai — DATE OF BURIAL: May 9 1920

20. UNDERTAKER: Home — ADDRESS:

See instructions on back of certificate. ment of OCCUPATION is very important.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 16872

Juliaetta Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30547

Registered No. ____

Registration District No. 68

Primary Registration District No. ____

1. PLACE OF DEATH.

County of Latah

City of Juliaetta (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorel Andrew Weatherby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 18 (Day) 1719 (Year)

7. AGE: ____ Yrs. 6 Mos. 21 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ben. H. Weatherby

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Francis E. Buckalew

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leader Buckalew

(Address) Juliaetta Ida

15. Filed May 10 1920 R. F. Pepple Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7th 1920, to May 8th 1920, that I last saw him alive on May 8th 1920, and that death occured on the date stated above, at 5-A M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) ____ Yrs. ____ mos. 6 ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) W. A. Rothwell M. D.

May 10 1920 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Fir Ridge Cemetery — DATE OF BURIAL: May 10 1920

20. UNDERTAKER: J. A. Grosvelore — ADDRESS: Juliaetta Ida

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30548
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Kendrick
(No. ....., ... St.)
Registration District No. 68
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman C Brauer

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married
6. DATE OF BIRTH: May (Month) 14 (Day) 1872 (Year)
7. AGE: 48 yrs. 3 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work. Retail Lumberman
(b) General nature of industry business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Germany
10. NAME OF FATHER: Brauer
11. BIRTHPLACE OF FATHER (State or Country): Germany
12. MAIDEN NAME OF MOTHER: Do not Know
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A R Brauer
(Address) Marion Wash
15. Filed May 15 1920 R F Pepple Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 13 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 2 1920 to May 13 1920
that I last saw h.. alive on May 13 1920
and that death occurred on the date stated above, at 11 a M.
The CAUSE OF DEATH* was as follows:

Dr Catarrhal Fever

..... (Duration) 2 yrs. 6 mos. ..... ds.
Contributory (Secondary) Rheumatism
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D D Kimball M. D.
May 15 1920 (Address) Kendrick Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Davenport Wash
DATE OF BURIAL: May 15 1920
20. UNDERTAKER: D D Kimball
ADDRESS: Pullman Wash

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Juliaetta Ida

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Juliaetta

Registration District No. 68
Primary Registration District No.
(No. , St.)

File No. 30549
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harietta Doe

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe
4. COLOR OR RACE: wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Dont Know 1 (Month) (Day) (Year)

7. AGE: 103 yrs. mos. ds.
IF LESS than 1 day how many hrs. or min?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Trust
(Address): Juliaetta Ida

15.
Filed 5-20 1920 R.T. Pepple Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 18th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1918, to May 17th 1920 that I last saw her alive on May 17th 1920 and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. A. Rothwell M. D.
May 19 1920 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Juliaetta Ida
DATE OF BURIAL: 5/20 1920

20. UNDERTAKER: E E Beckstead
ADDRESS: Kendrick Ida

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2170

(No. ..... St.)

File No. 30551

Registered No. 47

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Wargstrom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Dec 16 1860 (Month) (Day) (Year)

7. AGE: 59 Yrs. 4 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Andrew Wargstrom

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. C. Wargstrom

(Address) Howe Idaho

15. Filed 6/1 1920 W Cummins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 22 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Asthma

"No Doctor"

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W Cummins M. D.

6/1 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls

DATE OF BURIAL: 4/24 1920

20. UNDERTAKER: E E Dunwoody

ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21 V 70
File No. 30552
Registered No. 47

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Presley Martin Jr
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Infant

6. DATE OF BIRTH: Feby (Month) 16 (Day) 1920 (Year)

7. AGE: 0 Yrs. 1 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Presley Martin

11. BIRTHPLACE OF FATHER (State or Country) Okla.

12. MAIDEN NAME OF MOTHER Ellen Millard

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Presley Martin
(Address) Idaho Falls Ida

15. Filed 6/1 19 20 W Hammond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:
No Doctor
found dead in bed
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C Emmerson M. D.
3/26 19 20 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Taylor Ida	3/26 1920
20. UNDERTAKER	ADDRESS
C Underwood	Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2170
(No. ....., ... St.)

File No. 30553
Registered No. 73
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrel Barry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: Aug (Month) 29 (Day) 1897 (Year)
7. AGE: 72 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: A Farmer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Richard R Barry
11. BIRTHPLACE OF FATHER (State or Country): Ill
12. MAIDEN NAME OF MOTHER: Sadie Hopkins
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R R Barry
(Address) City
15. Filed 6/1 1920 W Lemmond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 20 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 5P M.
The CAUSE OF DEATH* was as follows: Unknown
Cerebral hemorrhage
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W Lemmond M. D.
3/20 1920 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	3/24 1920
20. UNDERTAKER	ADDRESS
C E Dunwoody	Ida Falls

No Physician

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30554

Registered No. 82

Registration District No. 23

Primary Registration District No. 2170

1. PLACE OF DEATH

County of Bonneville

City of Ida Falls

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Clifford Alias A. H. Churchill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	?

6. DATE OF BIRTH ?

..... (Month) ..... (Day) 1 (Year)

7. AGE about 45 yrs. ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE ?
(State or Country)

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER ?
(State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER ?
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. E. Dunwoody

(Address) Celey

15. Filed 6/1 1920 W. Dunwoody
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

January (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1920 to June 5 1920 that I last saw h— alive on June 4 1920 and that death occurred on the date stated above, at 8a M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Shupe M. D.

1/10 1920 (Address) Ida Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ida Falls

DATE OF BURIAL 1/10 1920

20. UNDERTAKER C. E. Dunwoody

ADDRESS Ida Falls

Dr. Shupe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30555
Registered No. A1

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3
Primary Registration District No. 2 1 V
(No. ..... St.)

2. FULL NAME Etta Christine Black

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 10 (Day) 1893 (Year)

7. AGE: 76 Yrs. 5 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Chris Meltvedt

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Ch Susanna Jacobson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C Meltvedt
(Address) Idaho Falls

15. Filed 6/1 1920 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1920, to Feb 22 1920, that I last saw h[er] alive on Feb. 21 1920, and that death occurred on the date stated above, at 1.09 M.
The CAUSE OF DEATH* was as follows:

Influenza - Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Harry E. Wilson M. D.
2/23 1920 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Boise, Idaho
DATE OF BURIAL: 2/23 1920

20. UNDERTAKER: C E Dunwoody
ADDRESS: Ida Falls

Dr H L Wilson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
(No. ..... St.)

File No. 30556
Registered No. 20

1. PLACE OF DEATH,
County of Bonneville
City of Idaho Falls.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katsuno Morizono.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Japan
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 23rd (Day) 1917. (Year)

7. AGE: 2 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls. Idaho.

10. NAME OF FATHER Daikichi Morizono.

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER Yukino Morizono.

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Idaho Falls, Idaho.

15. Filed March 1/20 191.... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March (Month) 16th, (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowning
accidental
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C E Dunwoody Coroner D.
3/17 1920 (Address) Ida Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls. DATE OF BURIAL: 3/18 1920

20. UNDERTAKER: C E Dunwoody ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE-YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30557

Registered No. 75

Registration District No. 73

Primary Registration District No. 2710

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Idaho Falls

2. FULL NAME Angus Nevell Raty

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. Oct (Month) 8 (Day) 1908 (Year)

7. AGE: 11 Yrs. 4 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph Raty

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ida Nettie Pinney

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. Dunwoody

(Address) Idaho Falls

15. Filed 6/1 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 1 1920, to Mch 5 1920, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Appendecitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... Yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

3/6 1920 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 3/6 1920

20. UNDERTAKER: C. C. Dunwoody — ADDRESS: Id. Falls

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30558

Registered No. 72

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

(No. ..... St.)

Registration District No. 73

Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm John Earls

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. March 9 1918
(Month) (Day) (Year)

7. AGE: 1 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edgar Earls

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Ethel Sabbstrom

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edgar Earls

(Address) City

15. Filed 4/1 1920 W. Hammond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 5 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 5 1920, to Mch 5 1920, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Toxemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Allen M. D.

3/6 1920 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 3/8 1920

20. UNDERTAKER: C. E. Dunwoody — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30559

Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13

Primary Registration District No. 2170

(No. ....., ... St.)

2. FULL NAME Frances Jane Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) (Day) 1885 (Year)

7. AGE: 34 Yrs. 9 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... at Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John J. Barnes

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Hannah Douglas

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Chas Phillips

(Address) Mcan Ida

15. Filed 6/1 1920 C Townsend Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1920, to March 10 1920, that I last saw h..... alive on ..... 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C E Sullivan M. D.

3/ 1920 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mcan Ida — DATE OF BURIAL: Mar 1920

20. UNDERTAKER: E E Sherwood — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

D Clerk

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
File No. 30560
Registered No. 76

1. PLACE OF DEATH
County of Bonneville
City of Ida Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac Butterworth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 8 (Day) 1868 (Year)

7. AGE: 51 Yrs. 8 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm Butterworth

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Rose

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs I Butterworth
(Address) Idoho Falls

15. Filed 6/1 1920 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 17 1920 to March 17 1920
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:

Contusion Chest — Fractured ribs — Internal Injuries

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Cline M. D.
3/20 1920 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 3/22 1920

20. UNDERTAKER: C C Sherwood — ADDRESS: Ida Falls

Dr C M Cline

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30561
Registered No. 70

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 2 1 4 b
(No. ....., ... St.)

2. FULL NAME Elizabeth Oley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: April (Month) 20 (Day) 1833 (Year)

7. AGE: 86 Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm ~~Skelton~~

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane ~~Simpson~~ Skelton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Oley
(Address) Idaho Falls Ida

15. Filed 6/1 1920 W Kinnard
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 7 1920, to April 7 1920
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
4/10 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida — DATE OF BURIAL: 4/11 1920

20. UNDERTAKER: C E Dennoden — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Dr Cline

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21 J 70
File No. 30562
Registered No. 74

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rendell Henry Petersen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May (Month) 1 (Day) 1901 (Year)

7. AGE: 19 Yrs. 11 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): Student

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Carl N Petersen

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Lundblade

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C N Petersen
(Address) Idaho Falls

15. Filed 6/1 1920 C Hummard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 19 1920, to Apr 19 1920, that I last saw him alive on Apr. 19 1920, and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Pneumonia
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Acute Nephritis
(Duration) ..... yrs. 7 mos. ..... ds.
(Signed) A P Soderquist M. D.
4/28 1920 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	5/2 1920

20. UNDERTAKER	ADDRESS
E Eldredge	Idaho Falls

A P Soderquist

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30563

Registration District No. 73

Primary Registration District No. 2170

Registered No. 73

1. PLACE OF DEATH

County of Bannock

City of Idaho Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo Payne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 11 (Day) 1838 (Year)

7. AGE: 81 Yrs. 8 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Charles Payne

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Norton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Geo Payne

(Address) Idaho Falls

15. Filed Jan 1 19 20 W Hammond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 26 1919, to Feb 17 1920, that I last saw him alive on Feb 17 1920, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Stone in bladder

(Duration) Several Yrs. ..... mos. ..... ds.

Contributory (Secondary) Prostatitis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W Pendleton M. D.

1/30 1920 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls | DATE OF BURIAL: 1/31 1920

20. UNDERTAKER: E E Lunceford | ADDRESS: Idaho Falls

D Pendleton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51089

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2103
File No. 30566
Registered No. 71

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lena Maxine Gray.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: June (Month) 11 (Day) 1919 (Year)

7. AGE: 0 Yrs. 7 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho Falls, Ida

10. NAME OF FATHER: Geo. G. Gray

11. BIRTHPLACE OF FATHER (State or Country): Kansas City, Mo

12. MAIDEN NAME OF MOTHER: Mary Bankhead

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. G. [illegible]
(Address) Idaho Falls Ida

15. Filed Apr 8 1920 [illegible] Local Registrar
Dr Hollister

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: January (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1-23-1920, to 1-29-1920, that I last saw h.r alive on 1-29-1920, and that death occurred on the date stated above, at 1a M.
The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Hollister M. D.
Jan 30 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 2/2 1920

20. UNDERTAKER: E. E. Linwood Lee — ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30567

Registration District No. 73
Primary Registration District No. 21V-9
(No. ..... St.)
Registered No. 76

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Jefferson
City of Hamer

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Gurman

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified, Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feby (Month) 19 (Day) 1886 (Year)

7. AGE 34 Yrs. 0 Mos. 14 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arizona

10. NAME OF FATHER: J R Gurman

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Sarah Ricks

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Gurman
(Address) Hamer Ida

15. Filed Mch 20 1930
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1, 1930, to March 3 1930, that I last saw h[illegible] alive on March 3 1930, and that death occured on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) about 2 wks. Yrs. mos. ds.

Contributory (Secondary) Pneumonia

(Duration) 10 Yrs. 1 mos. 3 ds.

3/6 1930 (Signed) [illegible] M. D.
(Address) Idaho Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 3/7 1930

20. UNDERTAKER: C E Linwoodey — ADDRESS: Ida Falls

Dr Nelson

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30568

Registered No. 69

1. PLACE OF DEATH

County of Jefferson

City of Hamer

Registration District No. 73

Primary Registration District No. 2142

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Hall Swinburne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 20 (Day) 1859 (Year)

7. AGE: 60 Yrs. 8 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Or Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington D.C.

10. NAME OF FATHER: Albert G Hall

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: ? Rich

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A Swinburne

(Address) Hamer

15. Filed Mr 28 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1920 to March 3 1920 that I last saw h[illegible] alive on March 1 1920 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia -
Rheumatoid arthritis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) Several yrs. ..... mos. ..... ds.

(Signed) Harry R Willson M. D.

3/4 1920 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Ship

19. PLACE OF BURIAL OR REMOVAL: St Paul Minn

DATE OF BURIAL: 3/5 1920

20. UNDERTAKER: C E Dunwoody

ADDRESS: Idaho Falls

Dr Allen E

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30569

Registered No. 64

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2 U 0

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laura Eliz. Ball

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Apr (Month) 5 (Day) 1886 (Year)

7. AGE 33 Yrs. 10 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: W H Hatch

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Martha A Hancock

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Berry Ball

(Address) Ida Falls, Ida

15. Filed Apr 28 1920 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 18, 1920, to Feb. 27, 1920, that I last saw h e r alive on Feb. 27, 1920 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O Mellor M. D.

Feb 29 1920 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Cemetery, Ida. DATE OF BURIAL: Mch 2 1920

20. UNDERTAKER: C E Linwood ADDRESS: Ida Falls

BYNS - YORK CO., PTRS. & SOLS. 24653

D Mellon

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30570

Registered No. 67

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2170

(No. ..... St.)

2. FULL NAME Melvin Grant Ball

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. (Month) January (Day) 1 1920 (Year)

7. AGE: 0 Yrs. 1 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Leonard Ball

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Russell

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonard Ball

(Address) R D 3 Celj

15. Filed Feb. 2 1920 Effie Summers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Feby (Day) 19 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 15, 1920, to Feb. 19, 1920, that I last saw h[illegible] alive on Feb. 16 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Bronchio pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) John O. Mellor M. D.

2/19 1920 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ammon, Ida — DATE OF BURIAL: 2/20 1920

20. UNDERTAKER: E E Dunwoodley — ADDRESS: Ida Falls

Dr Mellor

EVANS - VOSS CO., PTGS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 3057
Registered No. 66

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Welch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 28 (Month) (Day) 1868 (Year)

7. AGE: 51 Yrs. 9 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John N. Welch

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Billings

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. N. Welch
(Address) St Anthony

15. Filed May 22 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1920, to May 22 1920
that I last saw h. alive on May 22 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
5/22 1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Anthony Ida
DATE OF BURIAL: May 1920

20. UNDERTAKER: [illegible]
ADDRESS: Idaho Falls

Dr Olive

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
File No. 30572
Registered No. .....

1. PLACE OF DEATH.
County of Custer
City of Macray
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oscar Wallancort -

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. 4 (Month) 27 (Day) 1856 (Year)

7. AGE: 64 Yrs. 1 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Francis Wallancort

11. BIRTHPLACE OF FATHER (State or Country): U.S.?

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Wallancort
(Address) Macray, Idaho.

15. Filed 6/12 1920 Roy Maracle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/19 1920, to 5/24 1920, that I last saw h[illegible] alive on 5/24 1920, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis -

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary): Renal Uremia -

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) F. P. Miranda M. D.

6/5 1920 (Address) Macray Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGR. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

30573

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Teton

City of Driggs

Registration District No. 77

Primary Registration District No. 2176

(No. ....., ... St.)

File No. 20

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillie Grace Byrne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. June (Month) 16 (Day) 1902 (Year)

7. AGE: 17 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Living at home

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Teton Co. Idaho

10. NAME OF FATHER: Michael Byrne

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Hattie Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Michael Byrne

(Address) Driggs Idaho

15. Filed June 1st 1920 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1920, to May 26 1920, that I last saw her alive on 25 May 1920, and that death occured on the date stated above, at 7 AM.

The CAUSE OF DEATH* was as follows:

Diabetis Melitus

(Duration) 1 Yrs. 4 mos. ..... ds.

Contributory (Secondary) Diabetic Coma

(Duration ..... yrs. ..... mos. 1 ds.

(Signed) H. H. Culbertson M. D.

May 26 1920 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Darby Teton Co. Idaho

DATE OF BURIAL: May 28th 1920

20. UNDERTAKER .....

ADDRESS .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

30574

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 19
Registered No.

1. PLACE OF DEATH.
County of Lincoln
City of Jackson Wyo (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Shirley Jene Ricks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
March (Month) 3 (Day) 1917 (Year)

7. AGE
3 Yrs. 2 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho.

10. NAME OF FATHER: David Ricks

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER: Eva Jane Little

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) David Ricks
(Address) Jackson Wyo.

15.
Filed May 24th 1920 Martha Marker
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental
Drowning

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) The Childs Father M. D.
.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clawson, Idaho — DATE OF BURIAL: May 25th 1920

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

30575

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 21
Registered No.

1. PLACE OF DEATH
County of Teton
City of Driggs
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vina Stella Beman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 8th 1902 ~~1920~~ (Month) (Day) (Year)

7. AGE: 18 Yrs. 1 Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School-Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Heber J. Beman

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mariah Little

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Eva Beman
(Address): Tetonia Ida

15. Filed June 7th 1920 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 31 1920 to June 4 1920 that I last saw h[illegible] alive on June 4 1920, and that death occurred on the date stated above, at 1.50 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
Complicated by and Acute Lobar Pneumonia
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Chas J Martin M. D.
June 6 1920 (Address) Driggs, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tetonia Idaho — DATE OF BURIAL: June 6 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30576

Registration District No. 78
Primary Registration District No. 2155
Registered No.

1. PLACE OF DEATH
County of Bonner
City of
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Graves
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: May 8, 1839 (Month) (Day) (Year)

7. AGE: 81 Yrs. Mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Logger, in Woods (Retired)
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): N. H.

10. NAME OF FATHER: Wm Graves

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Edith Hamster

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benj Graves
(Address) Sandpoint, Ida

15.
Filed June 8 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May, 18, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May-10-1920 to May-18 1920
that I last saw him alive on May-16 1920,
and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows: Interstitial Nephritis Chronic

(Duration) 6 Yrs. mos. ds.
Contributory (Secondary) Arteriosclerosis.
(Duration) ! yrs. mos. ds.

(Signed) [redacted] M. D.
June 8 1920 (Address) [redacted] Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint — DATE OF BURIAL: May 20 1920.
20. UNDERTAKER: [redacted] — ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30577
Registered No.

1. PLACE OF DEATH
County of Boundary
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79
Primary Registration District No. 1453
(No. City Hospital St.)

2. FULL NAME John Doe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Unknown

6. DATE OF BIRTH: Unknown (Month) (Day) 1844 (Year)

7. AGE: 76 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Unknown
(b) General nature of industry, business or establishment in which employed (or employer): "

9. BIRTHPLACE (State or Country): "

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) County Poor Farm
(Address) Sandpoint, Ida.

15. Filed June 8 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1919, to June 5 1920
that I last saw h.i.m. alive on June 4 1920
and that death occurred on the date stated above, at 12 1/2 P.M.
The CAUSE OF DEATH* was ~~as follows~~:
Pulmonary Tuberculosis
Hemoptysis
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) F. Boyd Clarke M. D.
6-5 1920 (Address) Sandpoint Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 16 days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence County Poor Farm

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida.
DATE OF BURIAL: June 7, 1920
20. UNDERTAKER: [illegible]
ADDRESS: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30578
Registered No.

Registration District No. 78
Primary Registration District No. 2105

1. PLACE OF DEATH
County of Bonner
City of Colburn
(No. Colburn, Ida. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna May Shannon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 1 (Day) 1893 (Year)

7. AGE: 27 Yrs. 9 Mos. [illegible] ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woman-Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Okla

10. NAME OF FATHER: W. E. Haines

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Mary Perkins

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Shannon
(Address) Colburn, Ida

15. Filed June 8 1920 FLOYD G. WENDLE Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1920 19 ..., to May 4 1920 19 ..., that I last saw her alive on May 4 1920, and that death occurred on the date stated above, at 5:00 A.M.
The CAUSE OF DEATH* was as follows:

Puerperial Sepsis.

(Duration) — Yrs. — mos. 5 ds.
Contributory (Secondary): Child Birth.
(Duration) ... yrs. ... mos. ... ds.

(Signed) C. P. Gerkold M. D.
May 6 1920. (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Naples, Ida.

19. PLACE OF BURIAL OR REMOVAL: Colburn, Ida — DATE OF BURIAL: May 6 1920

20. UNDERTAKER: [illegible] — ADDRESS: Sandpoint Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 30579
Registered No.

1. PLACE OF DEATH
County of Boundary
City of Sandpoint
(No. 715 Church St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Marie Marquis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6. DATE OF BIRTH: May (Month), 30 (Day), 1876 (Year)

7. AGE: 56 Yrs. 11 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Michael Lavassant

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Philomena ?

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ernest Marquis
(Address) Sandpoint, Ida.

15. Filed June 8 1920 FLOYD G. WENDLE Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month), 14 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-18 1919, to 5-15 1920 that I last saw her alive on 5-14 1920, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:
Melanotic Carcinoma
Mandible and Pituitary Gland
(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) E T Anderson, M. D.
5/15 1920 (Address) Sandpoint Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida.	May 17, 1920.
20. UNDERTAKER: E. B. Pease	ADDRESS: Sandpoint Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30580

Registered No.

1. PLACE OF DEATH

County of Bonner

City of Garnet

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 12 [illegible]

(No. Garnet, Ida. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha A. McCracken

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	widow

6. DATE OF BIRTH: July (Month) 30. (Day) 1860 (Year)

7. AGE: 59 Yrs. Mos. 9 ds. 17

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: [redacted] Bonning

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Martha Bonning

13. BIRTHPLACE OF MOTHER (State or Country): [redacted] Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy McCracken

(Address) Garnet, Idaho

15. Filed June 8 1920

FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1918, to May 16th 1920, that I last saw her alive on May 9th 1920 and that death occurred on the date stated above, at 5.00 a. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

over (Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Frank Wenz M. D.

5/16 1920. (Address) Rathdrum, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Athol Ida | DATE OF BURIAL: May 17 1920

20. UNDERTAKER: O. W. Stone | ADDRESS: Rathdrum Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30581

Registered No.

Registration District No. 78

Primary Registration District No. 2135

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

(No. 1210 Oak St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Kerr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Sept. (Month) 11 (Day) 1844 (Year)

7. AGE: 76 Yrs. 7 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Henry Kerr

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Julia M. Bates

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Stuart Kerr

(Address) Sandpoint, Ida.

15. Filed June 8 1920 FLOYD G. WENDLE Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29, (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw him alive on ..... 19.....,

and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

This woman was in a state of coma but died of Diabetes Mellitus

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Carcinoma

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) Sand Point Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: May 31, 1920.

20. UNDERTAKER: E. W. Funk ADDRESS: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

Primary Registration District No. 2105

File No. 30582

County of Bonner

City of Sandpoint (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary - Olstein

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH

Mar. (Month) 1 (Day) ..... (Year)

7. AGE

90 Yrs. – Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Olstein

(Address) Mt Vernon Wash.

15. Filed June 9 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Feb. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH was as follows:

Angina Pectoris

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H M Knapp M. D.

2-25 19 20 (Address) Hope Idaho.

*State the Disease Causing Death; or if deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Idaho	2/25 19 20
20. UNDERTAKER	ADDRESS
C. C. Brown	Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Stackhouse

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2153
File No. 30583
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lepie Smith Shields

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~ (Write the word.): Single

6. DATE OF BIRTH: March (Month) 26 (Day) 1926 (Year)

7. AGE: ~~Yrs.~~ ~~Mos.~~ 1 Day 12 Hrs ~~dy. 7 Hrs.~~ IF LESS than 1 day how many ~~dy.~~ hrs. ~~ps.~~ ~~min.~~?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sandpoint Idaho.

10. NAME OF FATHER: Alexander Shields.

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City, Utah.

12. MAIDEN NAME OF MOTHER: Sophia Almeda Smith.

13. BIRTHPLACE OF MOTHER (State or Country): Kanarraville Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Alexander Shields
(Address): Sand Point Ida.

15. Filed June 9 1926

FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 27 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth 3/26 1926, to Mar 27 1926.
that I last saw h in alive on Mar 26 1926
and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Premature birth -
(Maternal Flu)
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. P. Stackhouse M. D.
19 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida. DATE OF BURIAL: Mar 28 1926

20. UNDERTAKER: [illegible] ADDRESS: Sandpoint

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30585
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2137

2. FULL NAME Mary Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 11 (Day) 1876 (Year)

7. AGE: 44 Yrs. — Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: John Peterson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Andre Martinson

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Olson
(Address) Sandpoint.

15. Filed June 8 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Acute Cardiac Dilatation
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H M Knapp M. D.
4/4 1920 (Address) Hope Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint Ida	4/6 1920
20. UNDERTAKER	ADDRESS
E M Bowers	S P.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 215-1
File No. 30588
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint.
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME "Baby" Kaster. Male
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 22 (Day) 1920 (Year)

7. AGE: ~~0~~ Yrs. Mos. ds.
IF LESS than 1 day how many 1 hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Peter Kaster

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Clara O'Leary

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dennis O'Leary
(Address) Sandpoint, Ida.

15. Filed 2/27 1920 June 9
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12 p.m. birth, 22 1920, to Feb 22 1920, that I last saw h.im alive on Feb 22 1920, and that death occurred on the date stated above, at 1.45 a.M.

The CAUSE OF DEATH* was as follows:
Premature birth
(Maternal Flu)
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. P. Hackamore M. D.
19 (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: 2/22 1920

20. UNDERTAKER: E M Brower — ADDRESS: Sd.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2153
File No. 30589
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Hester
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 28 (Day) 1895 (Year)

7. AGE: 24 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Dennis O'Leary

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Anna DeClare

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dennis O'Leary
(Address) Sandpoint Ida

15. Filed June 9 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1919, to Mar 2 1920, that I last saw her alive on Mar 2 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Jan 2/20 Pneumonia 2/10 to 2/12
Cheyne-Stokes 2-22
Acute cardiac dilatation - 1 hr.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. P. Starkhouse M. D.
19 (Address) Sandpoint Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida
DATE OF BURIAL: 3/4 1920
20. UNDERTAKER: E. M. Brower
ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30590
Registered No. .....

Registration District No. 79
Primary Registration District No. 3156
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Boundary
City of Copeland

2. FULL NAME Tina Sue Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov (Month) 8 (Day) 1919 (Year)

7. AGE ..... Yrs. 6 Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER J. Arvan Brown

11. BIRTHPLACE OF FATHER (State or Country) Grace

12. MAIDEN NAME OF MOTHER Myrtle Bailey

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Arvan Brown
(Address) Ephrata Wash

15. Filed 5/10/ 19..
E. E. Fry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... May (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1920 to ..... 191...
that I last saw h.r alive on May 7 1920.
and that death occurred on the date stated above, at ....., ...M.
The CAUSE OF DEATH* was as follows:

Marasmus

..... (Duration) ..... Yrs. 2 mos. 2 ds.

Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) S. T. Faucett M. D.
5/10/ 19 20. (Address) Bonners Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Copeland Ida — DATE OF BURIAL May 11 1920

20. UNDERTAKER O R Stookey — ADDRESS Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30591
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 79.
Primary Registration District No. 215-6.
(No. ....., ... St.)

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Belle D. Stinkle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. May (Month) 4 (Day) 1872 (Year)
7. AGE: 48 Yrs. ..... Mos. 0 ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Mich
10. NAME OF FATHER: Robert Hudson (Union)
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Elizabeth Hudson
13. BIRTHPLACE OF MOTHER (State or Country): Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde Stinkle
(Address) Bonners Ferry
15. Filed 5/15/ 1920 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 4 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1919 to May 14 1920
that I last saw her alive on May 12 - 1920
and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:
Nephritis
(Parenchymatous)
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) E E Stone M. D.
5/15/1920 (Address) Bonners Ferry

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Idaho — DATE OF BURIAL: May 16 1920
20. UNDERTAKER: A Bloodgood — ADDRESS: Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30593

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 32
Registered No. 3319

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. St Anthony Hospital)
If death occurs away from usual residence, *give facts* called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Inez Ovell Hagen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 8 (Day) 1897 (Year)

7. AGE: 22 yrs. 11 mos. 16 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James C. Smith

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Emma D Needham

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P L Hagen
(Address) Pocatello.

15. Filed May 25 1920 O B Steele Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10, 1920, to May 24 1920, that I last saw her alive on May 24 1920 and that death occurred on the date stated above, at 6 M.

The CAUSE OF DEATH* was as follows:
Pulmonary embolism

3 Days
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Ectopic gestation operation
(Duration) ..... yrs. 1 mos. 16 ds.

(Signed) O B Steele M. D.
May 25 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lakeview Mem. | DATE OF BURIAL: May 27 191

20. UNDERTAKER: Schumacher & Hall | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 79

Primary Registration District No. 2156

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30594
Registered No. .....

1. PLACE OF DEATH
County of Boundary
City of Meadow Creek
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Jorgensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH. ..... Aug (Month) ..... 21 (Day) ..... 1856 (Year)

7. AGE ..... 63 Yrs. ..... 9 Mos. ..... 17 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farming .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER Jorgen Olsen

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ..... Mrs Peter Jorgensen .....
(Address) ..... Meadow Creek Ida .....

15.
Filed June 9 ... 1930 ...
EE Fry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... June (Month) ..... 8 (Day) ..... 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
..... Apoplexy .....
..... (Death Ensuing in 5 min.) .....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory .....
(Secondary)
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) ..... EE Fry ..... M. D.
6/9 1930 (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 191...
Spokane Wash	
20. UNDERTAKER O R Stookey	ADDRESS Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30595

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32

Registered No. 3318

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 216

County of Bannock

City of Pocatello (No. St. Anthony Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy May Kinney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: June 8 1913 (Month) (Day) (Year)

7. AGE: 6 yrs. 11 mos. 15 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Idaho

10. NAME OF FATHER: James Lee Kinney

11. BIRTHPLACE OF FATHER (State or Country): Shoshone

12. MAIDEN NAME OF MOTHER: Stella Pepper

13. BIRTHPLACE OF MOTHER (State or Country): Idaho Falls Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J Lee Kinney
(Address): Montpelier

15. Filed May 27 1920 O R Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 23 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1920, to May 23 1920, that I last saw h[illegible] alive on May 23 1920, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Paralytic Obstruction of Bowel.

(Duration) yrs. mos. 1 ds.

Contributory (Secondary): Operation for Obstruction

(Duration) yrs. mos. ds.

(Signed) J. McSpadden M. D.

May 27 1920 (Address) Pocatello Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida. DATE OF BURIAL: May 26 1920

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30597

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 32
Registered No. 3316

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. Lynn Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret W Adamson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 16 (Day) 1871 (Year)

7. AGE: 48 yrs. 10 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: John Whitelaw

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margaret Harvey

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. K. Adamson
(Address) Pocatello

15. Filed May 22 1920 O B Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13th 1920, to May 21st 1920, that I last saw her alive on May 21st 1920, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Suppression of Urine

(Duration) yrs. mos. 3 ds.

Contributory (Secondary) Cancer, Intestines + Operation

(Duration) yrs. 4 mos. ds.

(Signed) W Lyman M. D.

May 22 1920 (Address) Pocatello Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 8 days. In the State ..... yrs. ..... mos. ..... days. (Lynn Hospital)
Where was disease contracted if not at place of death?
Former or usual residence Pocatello, Ida.

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Utah | DATE OF BURIAL: May 24 1920

20. UNDERTAKER: Schumacher + Hagg | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

30598

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. St. Anthony Hospital st.)

File No. 32
Registered No. 3315
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fredrick Richard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married

6. DATE OF BIRTH: January 1 (Month) (Day) 1850 (Year)

7. AGE: 70 yrs. 4 mos. 20 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Richard

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs F. Richard
(Address): Pocatello

15. Filed May 22 1920 O B Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1920, to May 21 1920
that I last saw h~~is~~ alive on May 21 1920
and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:

Diabetes Mellitis

(Duration) Few yrs. — mos. — ds.
Contributory (Secondary) Gangrene left leg Amputation
(Duration) — yrs. — mos. 10 ds.

(Signed) W. T. Howard M. D.
5/22 1920 (Address) Pocatello, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death? Pocatello Idaho
Former or usual residence: Same

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem | DATE OF BURIAL: May 23 1920

20. UNDERTAKER: Schumacher & Hall | ADDRESS: Same

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30599

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32

Registered No. 3314

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2161

County of Bannock

City of Pocatello (No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe Reggo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: November — 1896 (Month) (Day) (Year)

7. AGE: 23 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Italy

10. NAME OF FATHER: Dominick Reggo

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Theresa Lupen

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rose Pellegrens
(Address) Pocatello

15. Filed May 21 1920 O. B. Steel Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 20 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 1 1919, to May 20 1920 that I last saw h alive on May 20 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* [illegible]: Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

5/21 1920 (Address) Pocatello

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: May 24 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30600

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello. (No. 323 - 205 5th St.)

Registration District No. 84

Primary Registration District No. 2161

File No. 32

Registered No. 3313

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Stogdin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Colored	Wife

6. DATE OF BIRTH: Mar (Month) 26 (Day) 1891 (Year)

7. AGE: 29 Yrs. Mos. 27 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Monroe. La.

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence L Stogdin
(Address) 323 No 5th ave

15. Filed May 29 1920 O R Reed Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 19..., to ✓ 1920
that I last saw h... alive on ✓ 1920
and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Gun shot wound

.....(Duration) ...Yrs....mos....ds.
Contributory (Secondary)
.....(Duration) ✓ ...yrs....mos....ds.

(Signed) S S Ferguson + Coroner M. D.
4-23-1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs....mos....days. In the State ...yrs....mos....days
Where was disease contracted if not at place of death? ✓
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery | DATE OF BURIAL: 4-30 1920

20. UNDERTAKER: H. H. Walker | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

U. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30601 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 84

City of Pocatello — Primary Registration District No. 216

(No. Lynn Bros. St.)

File No. 32

Registered No. 3312

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ira Newell.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: Nov. 14. 1848 (Month) (Day) (Year)

7. AGE: 72 Yrs. 6 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Grace. Idaho

10. NAME OF FATHER: John Boyd.

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna Lebery

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William H Newell.

(Address) 546 - West Buxton.

15. Filed May 18 1920 O R Steel Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 — 1920 to May 16th 1920 that I last saw h[illegible] alive on May 17 1920 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary) confinement

(Duration) yrs. mos. ds.

(Signed) J W Lynn M. D.

5/19 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 day. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: 5/19 1920

20. UNDERTAKER: Bell Walker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30603 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 12
(No. 1111 N Main St.)
File No. 32
Registered No. 3310
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugene P Trone

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 4 (Day) 1896 (Year)

7. AGE: 24 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dayton Ohio

10. NAME OF FATHER: John C Trone

11. BIRTHPLACE OF FATHER (State or Country): Dayton Ohio

12. MAIDEN NAME OF MOTHER: Carrie Dady

13. BIRTHPLACE OF MOTHER (State or Country): Dayton Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. P. Trone
(Address) Pocatello Ida

15. Filed May 15, 1920 — O K Steele, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1920 to May 14th 1920, that I last saw him alive on May 14th 1920, and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:
Uremia

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Probably Chronic Nephritis
(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) [illegible] M. D.
May 15 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Cemetery	5/16 1920

20. UNDERTAKER: D. T. Packer — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30604 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 256
File No. 32
Registered No. 3309

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 522 No Arthur St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Freidaka Gack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Mar. 7 (Month) (Day) 1851 (Year)

7. AGE: 69 Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Saxony Germany

10. NAME OF FATHER: Gottschalk

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Rosa Gottschalk

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Barry Gack
(Address) 522 No Arthur

15. Filed May 15, 1920 O. B. Reed Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 14th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1920 to May 14th 1920, that I last saw her alive on May 14 1920 and that death occurred on the date stated above, at 8:45 A. M.

The CAUSE OF DEATH* was as follows:
Anaemia

(Duration) Yrs. 6 mos. ds.
Contributory (Secondary): Senility
(Duration) yrs. mos. ds.

(Signed) O. B. Reed M. D.
May 15 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City | DATE OF BURIAL: 5/16 1920

20. UNDERTAKER: P. I. Walker | ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

30606

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3.2
Registered No. 3323

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No.) Lynn Bros. Hosp

2. FULL NAME Jim Kirkos

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word) Single

6. DATE OF BIRTH. Nat K nown (Month) Born (Day) 1887 (Year)

7. AGE 37 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter and

(b) General nature of industry, business, or establishment in which employed (or employer): Car repairer O.S.L.

9. BIRTHPLACE (State or Country) Greece

10. NAME OF FATHER K. Kirkos

11. BIRTHPLACE OF FATHER (State or Country) Greece

12. MAIDEN NAME OF MOTHER Helen George

13. BIRTHPLACE OF MOTHER (State or Country) Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Steve Stamos

(Address) Lowell Cafe

15.

Filed May 20 1920

Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19th 1920 to May 19th 1920 that I last saw him alive on May 19th 1920 and that death occurred on the date stated above, at 7.45 P. M.

The CAUSE OF DEATH* was as follows: following auto accident fracture of 08-innominate & fright hip & shock

(Duration) ..... Yrs. ..... mos. 2 hours ds.

Contributory (Secondary) shock

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

May 19 1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos. 2 days. In the town yrs. mos. Pocatello days

Where was disease contracted if not at place of death? .....

Former or usual residence Salt Lake City Utah

19. PLACE OF BURIAL OR REMOVAL Salt Lake City Utah — **DATE OF BURIAL** May 20 1920

20. UNDERTAKER H. L. McKeen — **ADDRESS** Pocatello

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

30607

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3322

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 112 N. 2nd ave. St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kayesaburo Nishioka

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single
6. DATE OF BIRTH. Not Known (Month) (Day) (Year)
7. AGE: 47 Yrs. ... Mos. ... ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Japan
10. NAME OF FATHER: Nishioka
11. BIRTHPLACE OF FATHER (State or Country): Japan
12. MAIDEN NAME OF MOTHER: Not Known
13. BIRTHPLACE OF MOTHER (State or Country): Japan
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Japanese Association
(Address) Church & White Bld.
15. Filed May 14, 1920 — R. Steele, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 14 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 14 1920 to May 14 1920
that I last saw him alive on May 14 1920
and that death occurred on the date stated above, at 3:45 P. M.
The CAUSE OF DEATH* was as follows:
Myocarditis, Aortitis.
(Duration) 3 Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... Yrs. ... mos. ... ds.
(Signed) ... M. D.
5-15 1920 (Address) Am Newton
*State the Disease Causing Death; in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State 7 days yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence: Japan

19. PLACE OF BURIAL OR REMOVAL: Mt. View Cem — DATE OF BURIAL: May 15 1920
20. UNDERTAKER: H. L. McClain — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

30606

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32
Registered No. 3321.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. General Hosp St.)

2. FULL NAME Ruth Herbel

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH. May (Month) 10 (Day) 1920 (Year)

7. AGE: ... Yrs. ... Mos. 3 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: David J. Herbel

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Mattie Brinker

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David J. Herbel
(Address) 835 So. Harrison

15. Filed May 13 1920
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1920 to May 12 1920
that I last saw her alive on May 12 1920
and that death occurred on the date stated above, at 11:20 P. M.

The CAUSE OF DEATH* was as follows:

Influenza - acute

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary): age of 2 days.

(Duration) ... Yrs. ... mos. ... ds.

(Signed) H. M. Gay, M. D.
19... (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State ....yrs....mos....days
Where was disease contracted if not at place of death? Life
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: May 13 1920

20. UNDERTAKER: H. L. McClaso ADDRESS: Pocatello Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30610 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 85

Primary Registration District No. 2185

File No.

County of Bonner

City of Priest River, Ida (No. ..... St.)

Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Ritchey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 14 (Day) 1890 (Year)

7. AGE: 30 Yrs. — Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lumberjack.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: William Ritchey

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Melissa Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Walter Ritchey

(Address) Priest River, Ida.

15. Filed June 1 1920 C. P. Getzloff Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 7 1920, to May April 25 1920, that I last saw him alive on April 25 1920, and that death occurred on the date stated above, at 1.45 A.M.

The CAUSE OF DEATH* was as follows:

Abcess of right lung,

(Duration) — Yrs. 2 mos. 7 ds.

Contributory (Secondary) Spanish Influenza

(Duration) — Yrs. — mos. 27 ds.

(Signed) C. P. Getzloff M. D.

Mal 5 1920 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Priest River	May 7 1920
20. UNDERTAKER	ADDRESS
Wm Deming.	Newport.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CAUSE OF DEATH on back of certificate. in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See ins

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT ... MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30611

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 85

Primary Registration District No. 2185

File No. 1

County of Bonner

City of Priest River, Ida. (No. ....., ... St.)

Registered No. 20

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tom McNair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH Unknown (Month) ..... (Day) 1 (Year)

7. AGE Appros. 55 yrs. ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed June 1 1920. C. P. Getchell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 15 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw him alive on ..... 19.....

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acut Dilitation of Heart.
(Found by Post Mortem)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Getchell M. D.

May 16 1920 (Address) Priest River Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Newport, Wn.	May 28 1920

20. UNDERTAKER	ADDRESS
Wm. Davies	Newport, Wn.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30612
Registered No. 20

1. PLACE OF DEATH
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 2168
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dora Frear

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	white	widow (Write the word.)

6. DATE OF BIRTH: Dec (Month) 29 (Day) 1855 (Year)

7. AGE: 62 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Frear
(Address) Pingerment Ida

15. Filed June 1, 1920 J. M. Family Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1920, to May 19 1920, that I last saw h[illegible] alive on May 17 1920, and that death occurred on the date stated above, at 7:45 M.
The CAUSE OF DEATH* was as follows:
Acute indigestion
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Family M. D.
5/19 1920 (Address) Orofino, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Ida	5/ 1920
20. UNDERTAKER W. A. Shaw	ADDRESS Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 7168
File No. 30613
Registered No. 21

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Canton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	white	Single (Write the word.)

6. DATE OF BIRTH
June (Month) 30 (Day) 1 (Year)

7. AGE
69 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinist
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sophia Ida

10. NAME OF FATHER: Louis Canton

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: J. Talbot

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Phil Canton
(Address) Orofino Ida

15. Filed June 1 1920 J. M. Lamb Local Registrar

STEG-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw him alive on May 1 1920,
and that death occurred on the date stated above, at 7:00 A.M.
The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio-sclerosis
(Duration) ? yrs. ..... mos. ..... ds.

(Signed) J. M. Lamb M. D.
6/3 1920 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Ida	May 4 1920
20. UNDERTAKER W. A. Shaw	ADDRESS Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3614

Registered No. 38

1. PLACE OF DEATH. Registration District No. 90

County of Clearwater Primary Registration District No. 2168

City of Orofino Ida (No. ? St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma Strang

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	?

6. DATE OF BIRTH ? (Month) ? (Day) About 1849 (Year)

7. AGE About 71 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) America

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Wallace Clearwater
(Address) Orofino Ida

15. Filed June 1 1920 J. M. Craig Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH May 5 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1906 to May 5 1920 that I last saw her alive on May 5 1920 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity

..... (Duration) ? yrs. ..... mos. ..... ds.

(Signed) John Simeus, M. D.

5/6 1920 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 13 yrs. 11 mos. 8 days. In the State ? yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? ?

Former or usual residence Latah Co. Ida.

19. PLACE OF BURIAL OR REMOVAL Moscow Ida | DATE OF BURIAL 6/8 1920

20. UNDERTAKER Glen Grier | ADDRESS Moscow Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 2685
Registered No. 33

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH. Registration District No. 90

County of Clearwater Primary Registration District No. 2168

City of Orofino, (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles F. Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 26 (Day) 1852 (Year)

7. AGE: 67 yrs. 6 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Atteberry
(Address) Orofino, Ida.

15.
Filed June 1 1920 J. M. Riley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1920, to May 16 1920, that I last saw h[illegible] alive on May 16 1920, and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis

(Duration) ? yrs. ? mos. ..... ds.

Contributory (Secondary) Dysentery

(Duration) ? yrs. ? mos. ..... ds.

(Signed) J. Lewis Hines M. D.
5/18 1920 (Address) Orofino, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 29 days. In the State ? yrs. ? mos. ..... days.

Where was disease contracted if not at place of death? Does not know.

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. DATE OF BURIAL: 5/19 1920

20. UNDERTAKER: H. A. Shaw ADDRESS: Orofino

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 90
County of Clearwater
Primary Registration District No. 2168
City of Orofino, Idaho (No. ....., ... St.)
File No. 3616
Registered No. 3
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME Glenn R. Beedham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: About 1897 (Month) (Day) (Year) 1
7. AGE: About 23 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): None
9. BIRTHPLACE (State or Country): Wood Lake, Minnesota
10. NAME OF FATHER: ?
11. BIRTHPLACE OF FATHER (State or Country): ?
12. MAIDEN NAME OF MOTHER: ?
13. BIRTHPLACE OF MOTHER (State or Country): ?
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Givens
(Address) Orofino, Idaho,
15.
Filed June 1, 1920 J. M. Gault Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 25th (Day) 1920 (Year) 191
17. I HEREBY CERTIFY, That I attended deceased from Jan. 9th 1915, to May 25th 1920,
that I last saw h im alive on May 25th 1920
and that death occurred on the date stated above, at 12 Noon o'clock
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
About (Duration) 22 yrs. 4 mos. — ds.
(Signed) John W. Givens M. D.
May 25th 1920 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. 4 mos. 16 days. In the State about 18 yrs. — mos. — days.
Where was disease contracted if not at place of death?
Former or usual residence Gibbs, Kootenai County, Idaho.
19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 5/28 1920
20. UNDERTAKER: H. L. Pace
ADDRESS: Orofino

SYMS (YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36617

Registered No. 5

1. PLACE OF DEATH.

County of Nez Perce

City of Gifford

Registration District No. 92

Primary Registration District No. 2170

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna May Tennell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	white	single

6. DATE OF BIRTH.

3 (Month) 24 (Day) 1920 (Year)

7. AGE

..... Yrs. 1 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... at home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER John K Tennell

11. BIRTHPLACE OF FATHER

(State or Country) Mo

12. MAIDEN NAME OF MOTHER Elsie Curry

13. BIRTHPLACE OF MOTHER

(State or Country) Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J K Tennell

(Address) Gifford

15.

Filed 5-5 1920

E E Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1920, to May 5 1920, that I last saw her alive on May 2 1920, and that death occured on the date stated above, at 10 a M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Watts M. D.

5-5 1920 (Address) Gifford

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Melrose	5-6 1920

20. UNDERTAKER	ADDRESS
W E. Stoddard	Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 93
Primary Registration District No. 2371
File No. 30618
Registered No.

1. PLACE OF DEATH
County of Nez Perce
City of Reed
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stella Fay Groom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan. (Month) 5 (Day) 1900 (Year)

7. AGE: 20 Yrs. 5 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: John William Groom

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Jennie L. Banks

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Ethel Knopf
(Address): Lewiston

15. Filed 6/14 1920 Daniel Tyle, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1920, to June 13 1920, that I last saw h.r alive on June 13 1920, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary): Measles

(Duration) ..... yrs. ..... mos. 18 ds.

(Signed) J. M. Tuohy M. D.

6/17 1920 (Address) Grafton Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: 6/14 1920

20. UNDERTAKER: H. A. Shaw — ADDRESS: Orofino

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30619
Registered No. 404

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 618 F C 523 C St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME G. Wah

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Chinese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Vassar Coroner
(Address) Lewiston Idaho

15. Filed June 12 1920 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:

Gunshot wound, homicidal intent

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Vassar-Coroner

19... (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: 6 2 1920

20. UNDERTAKER: J. Vassar
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30620
Registered No. 405

1. PLACE OF DEATH
County of Nezperce
City of Lewiston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leatha Almeta Prescott
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 1 (Day) 895 (Year)

7. AGE: 25 Yrs. 3 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: H. S. Brown

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Rosia Chempers

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. S. Brown
(Address) Clarkston Wash.

15. Filed May 12 1920 — Swan E. Burr, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26 1920, to May 7 1920, that I last saw h. er alive on May 7 1920, and that death occurred on the date stated above, at 6-30 P.M.
The CAUSE OF DEATH* was as follows:

Embolism of brain

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. J. Mourse M. D.
19..... (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. 12 days. In the State — yrs. — mos. 12 days
Where was disease contracted if not at place of death? Clarkston Wash.
Former or usual residence Clarkston Wash.

19. PLACE OF BURIAL OR REMOVAL: Clarkston — DATE OF BURIAL: 5/9 1920

20. UNDERTAKER: H. P. Merchant — ADDRESS: Clarkston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30621
Registered No. 406

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 1928, Main St.)
Registration District No. 96
Primary Registration District No. 1909
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amos Grim

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Widower

6. DATE OF BIRTH: April (Month) 9 (Day) 1834 (Year)

7. AGE: 86 Yrs. ... Mos. 1 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer by former occupation
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Daniel Grim

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Not-Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daniel Grim
(Address) 192 Main St Lewiston Idaho

15. Filed June 12 1920 Susan E Burns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 30 1920, to May 9 1920 that I last saw him alive on April 30 1920 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Organic heart Disease
(Duration) Year. Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Paul W Johnson M. D.
May 10 1920 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	5/10 1920
20. UNDERTAKER	ADDRESS
J Hosa	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr J Johnson

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No.
File No. 30622
Registered No. 407

1. PLACE OF DEATH
County of Ivy Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Lewis Rubenseer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH
(Month) (Day) (Year) 1

7. AGE: 66 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: — Richdl

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Robert Rubenseer

15. Filed June 12 1920 Susan E Brees
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1920, to May 10 1920, that I last saw h[illegible] alive on May 10 1920, and that death occurred on the date stated above, at 10 55 A.M.
The CAUSE OF DEATH* was as follows:

Uraemic Convulsions
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Nephritis
(Duration) 1 yrs. mos. ds.
(Signed) O G Carson M. D.
19 (Address) Lewiston Idg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston
DATE OF BURIAL: May 11 1920

20. UNDERTAKER: C J Carson
ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30624
Registered No. 409

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 323, or 12th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ina Gilson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 10 (Day) 1887 (Year)

7. AGE: 42 Yrs. 5 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dressmaking
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William Gilson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elvira Sayre

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jennie Faulconer
(Address): Murray Idaho

15. Filed June 12 1920 — Anna E Bruce, Local Registrar

SUNSET PRESS CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1920, to May 16 1920, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:
Chronic valvular heart disease

(Duration) 1 year Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza ?
(Duration) 3 wks. mos. ..... ds.

(Signed) Paul D Johnson M. D.
5/18 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fonda Iowa — DATE OF BURIAL ..... 19.....

20. UNDERTAKER — ADDRESS

Johnson Fonda. Iowa.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30525
Registered No. 410

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Jack

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Single

6. DATE OF BIRTH March 25-52
(Month) (Day) (Year)

7. AGE 68 Yrs. 1 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Maine

10. NAME OF FATHER Augustus Jack,

11. BIRTHPLACE OF FATHER (State or Country) Maine

12. MAIDEN NAME OF MOTHER Alice Vogel

13. BIRTHPLACE OF MOTHER (State or Country) Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry F Bahmann
(Address) Pardee Idaho

15.
Filed June 22 1920
Swan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 17 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19.., to ..... 19.....
that I last saw h.. alive on May 17 1920,
and that death occurred on the date stated above, at 11 M.
The CAUSE OF DEATH* was as follows:

Stomach trouble

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dossor Corner M. D.
19.. (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Pardee
Former or usual residence "

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	5/18 1920
20. UNDERTAKER Dossor	ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lewiston, [illegible]

City of Nez Perce

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. ..... St.)

File No. 30626

Registered No. 411

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wallace Mathews Curry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: Nov. (Month) 11 (Day) 1913 (Year)

7. AGE: 6 Yrs. 6 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Reubens, Idaho

10. NAME OF FATHER: M.G.Curry

11. BIRTHPLACE OF FATHER (State or Country): Colorado

12. MAIDEN NAME OF MOTHER: Mabel Scott

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M.G.Curry

(Address) Reubens, Ida.

15. Filed June 12 1920 Irwin E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1920 to May 19 1920 that I last saw h.. alive on May 19 1920 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Spring turns over left Chest Lungs - Also inhaling fire Caused Pneumonia.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Fever

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. White M. D.

May 19 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Reubens, Ida. DATE OF BURIAL: May 20 1920

20. UNDERTAKER: H.R.Merchant ADDRESS: Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 30627
Registered No. 472

1. PLACE OF DEATH
County of Nez Perce
City or Lewiston (No. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. G. Shobbrook
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECORD
CIANS should state CAUSE OF DEATH
t. See instructions on back of certificate.

N. B.—Every item of inf
in plain terms, so that it

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

DATE OF BIRTH: Dec. (Month) 5 (Day) 81 (Year)

AGE: 38 Yrs. 5 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

OCCUPATION
Trade, profession or particular kind of work: Clerk,
General nature of industry, business or establishment in which employed (or employer):

BIRTHPLACE (State or Country): Canada.

NAME OF FATHER: Wm Shobbrook

BIRTHPLACE OF FATHER (State or Country): Canada.

MAIDEN NAME OF MOTHER: Martha Reed,

BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. J. Vassar
(Address) Lewiston

15. Filed June 12 1920 Norm E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5-12 1920; to 5-19- 1920.
that I last saw h.... alive on 5-19- 1920.
and that death occurred on the date stated above, at 2 30 M.
The CAUSE OF DEATH* was as follows:
Influenza Pneumonia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Cardio Vascular renal disease
(Duration) 5 yrs. ..... mos. ..... ds.
(Signed) W. F. McMahan M. D.
5-19 1920 (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston | DATE OF BURIAL: 20 1920

20. UNDERTAKER: C J Vassar | ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30629
Registered No. 414

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. St. Joseph Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bulah Killian

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Single

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1919 (Year)

7. AGE: Yrs. 5 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER E Killian

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Ellen Matlock

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lena Vanderpool
(Address) Almota Wash

15. Filed June 12 1920 Swan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1920 to May 28 1920 that I last saw h[illegible] alive on May 28 1920 and that death occurred on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) not known

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John W Alley M. D.

May 1924 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lenore Ida	5/29 19
20. UNDERTAKER Lasson	ADDRESS Lenore Ida

MARGIN RESERVED FOR BINDING — WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
Information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH
at it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
File No. 30630
Registered No. 415

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Wright
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Single

6. DATE OF BIRTH
July (Month) 23 (Day) 1 (Year)

7. AGE
29 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John Wright

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: Louisa Bowman

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): .....
(Address): Frank Wright

15. Filed June 12 1920 Susan E. Burns Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
4 (Month) - 29 (Day) - 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-28- 1920, to June 1920, that I last saw him alive on 4-28 1920, and that death occurred on the date stated above, at 3:30 P. M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary): .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W J McMahan M. D.
4-30 1920. (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston I
DATE OF BURIAL: 5/4 1920

20. UNDERTAKER: J Vassar
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30631

Registered No. 496

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. White Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E W Culver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... 1 .....
(Month) (Day) (Year)

7. AGE: 69 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N.Y.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C Clarence Culver

(Address) Emmett Ida

15.

Filed ..... 19 .....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 29 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1920 to May 29 1920 that I last saw h[illegible] alive on May 29 1920 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Uraemia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis Chronic

..... (Duration) 7 yrs. 9 mos. ..... ds.

(Signed) C. L. White M. D.

May 24 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Culdesac

DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: E J Lasson

ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 97
Primary Registration District No. 2174
(No. ....., ... St.)

File No. 30632
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Nez Perce
City of Myrtle
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank McKay

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May 13 (Month) (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Myrtle Idaho

10. NAME OF FATHER Kada A. McKay

11. BIRTHPLACE OF FATHER (State or Country) Kans

12. MAIDEN NAME OF MOTHER Elsie Maud Shoemake

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. M. Lytle M.D.
(Address) Lewiston Ida

15. Filed May 17 1920 William M. Hall Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1920 to May 13 1920, that I last saw h alive on May 13 1920 and that death occured on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
Impaired Vitality
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Lytle M. D.
5-12 1920 (Address) Lewiston

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery Myrtle Idaho
DATE OF BURIAL: May 17 1920

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 7 177
File No. 30653
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Newdale
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virgil Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 15 (Day) 1920 (Year)

7. AGE: ___ Yrs. ___ Mos. 8 ds. IF LESS than 1 day how many ___ hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fremont County.

10. NAME OF FATHER: Eli Clark Jr.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ella B. Tuck. ~~Clara Ricks~~

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Eli Clark Jr

15. Filed May 11 1920 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 1920, to April 22 1920, that I last saw him alive on April 22 1920, and that death occurred on the date stated above, at ___ M.

The CAUSE OF DEATH* was as follows:

Icterus neonatorum

(Duration) Since Birth Yrs. ___ mos. 5 ds.

Contributory (Secondary)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. Franck Watkins M. D.

April 23 1920 (Address) St Anthony, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Teton	Apr 24 1920

20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30634
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Neal Allen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: January 20 1840 (Month) (Day) (Year)

7. AGE: 80 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: James Henry Allen

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Nancy Jane Allen

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Allen
(Address) Ryby Idaho

15. Filed May 1 1920 W. H. Burt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 13 1920, to Apr 13 1920
that I last saw h[im] alive on Apr 13 1920
and that death occurred on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:
Myocarditis (Senile)

(Duration) 1 Yrs. — mos. — ds.
Contributory (Secondary) Chronic Nephritis & Influenza
(Duration) 1 yrs. — mos. — ds.

(Signed) J E Mellon M. D.
4 16 1920 (Address) J E Mellon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 19 yrs. mos. days. In the State 19 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence St Anthony Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pelton Cemetery	April 16 1920
20. UNDERTAKER	ADDRESS
Taylor - Eliason Co	St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 30635
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Blaine D Black

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 2 (Day) 1919 (Year)

7. AGE: 1 Yrs. 2 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) St Anthony Idaho.

10. NAME OF FATHER: Harry. Black.

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER: Mary L. Brick

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H H Black
(Address) St Anthony Idaho

15. Filed May 10 1920
W R Lloyd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1920 to April 24th 1920, that I last saw him alive on April 24th 1920, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia.
Nephritis Acute.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J Frank Hatkins M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milford Ida — DATE OF BURIAL: Apr 26 1920

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 98
County of Jefferson Primary Registration District No. 2176
City of Rigby (No. ..., St.) File No. 30636
Registered No. 11
If death occurs away from usual residence, give facts called for under special information. If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Hill Bybee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Babe

6. DATE OF BIRTH: Apr 14 1920 (Month) (Day) (Year)

7. AGE: ... yrs. 3 wks. 5 mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho -

10. NAME OF FATHER: Marion Bybee

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Pearl Edna Hill

13. BIRTHPLACE OF MOTHER (State or Country): Idaho -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pearl Edna Hill
(Address) Rigby, Ida

15. Filed 5-12 1920 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 11 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 191..., to ... 191..., that I last saw h... alive on ... 191..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

... (Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ...

... (Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

... 19... (Address) ...

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: May 12 1920

20. UNDERTAKER: Friends — ADDRESS: Rigby

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 3176
File No. 30637
Registered No. 18

1. PLACE OF DEATH.
County of Jefferson
City of Rigby (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jeston Later

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: Oct 31 1907 (Month) (Day) (Year)

7. AGE: 12 yrs. 3 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Sam S. Later

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Helena M Hayes

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S. S. Later
(Address) Rigby Idaho

15. Filed 5 - 10 1920 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 15 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 28 1920, to Feb 15 1920, that I last saw h[illegible] alive on Feb 14 1920, and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:
Cardiac Renal Insuff.
Lienery
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. I. Call M. D.
Feb 15 1920 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 2 - 17 1920

20. UNDERTAKER: Taylor Ellerson — ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30638

Registered No. 17

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 98

Primary Registration District No. 2176

County of Jefferson

City of Rigby (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wesley Eugene Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Baby

6. DATE OF BIRTH: Sept 5 (Month) (Day) 1919 (Year)

7. AGE: ..... yrs. 8 mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph H Peterson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Leah Tolley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos. H. Peterson
(Address) Rigby

15. Filed May 19 1920 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1920, to May 19 1920, that I last saw him alive on May 18 1920, and that death occurred on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:

Pertussis
Pneumonia
Cerebral irritation

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray H Fisher M. D.

5/19 1920 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby Ida	5/21 1920

20. UNDERTAKER	ADDRESS
Taylor-Ellison	Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30639
Registered No. 16

1. PLACE OF DEATH.
Registration District No. 98
Primary Registration District No. 2176
County of Jefferson
City of Rigby (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie Viola Harrington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	single

6. DATE OF BIRTH: Mch (Month) 13 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John B. Harrington

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Alice Conrad

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Harrington
(Address) Rigby, Ida

15. Filed May 10 1920 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Mch (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mch 13 1920, to Mch 16 1920, that I last saw h.. alive on Mch 16 1920 and that death occurred on the date stated above, at 1-30 A.M.

The CAUSE OF DEATH* was as follows:
Congenital stenosis of the oesophagus

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Starvation & atrecta

..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo S. Humphrey M. D.
Mch 17 1920 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191..

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98

County of Jefferson

Primary Registration District No. 2176

File No. 30640

City of Rigby (No. ....., ... St.)

Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: Feb 18 1920 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 20 mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Godfrey Klingler

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mabel Lee

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Godfrey Klingler
(Address) .....

15. Filed May 10 1920 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Feb 19 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 18 1920, to Feb 19 1920 that I last saw him alive on Feb 19 1920 and that death occurred on the date stated above, at 12 A M.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Atelectasis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo S. Humphrey M. D.

19 ..... (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
—	..... 191..
20. UNDERTAKER	ADDRESS
—	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30643

Registered No. 10

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 98

Primary Registration District No. 2176

County of Jefferson

City of Menan (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	White	Babe

6. DATE OF BIRTH: 4 (Month) – 14 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Benj R. Shippen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Annie Olaveson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benj R. Shippen
(Address) Menan, Ida

15. Filed 5 – 10 1920 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 4 (Month) – 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Premature Birth

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas S. Moody M. D.

4-14 1920 (Address) Menan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Annis	4-14 1920

20. UNDERTAKER	ADDRESS
—	—

SYMS - YORK CO., PTRS. & BDRS. 19780

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 30645
Registered No. 54

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William R Brimoto

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	Japan	Single

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1917 (Year)

7. AGE: 3 yrs. 3 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF FATHER: R. Arimoto

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Yuki Iwaiwa

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. Leo.
(Address) Rexburg

15. Filed 5/25 1920 G. Hope
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2:30 P.M. 5-24 1920 to 3 P.M. 5-24 1920 that I last saw him alive on 5-24 1920 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Concussion of Brain

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): Fall from buggy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. O. Martin M. D.

5-27 1920 (Address) Rexburg, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg — DATE OF BURIAL: 5-27 1920

20. UNDERTAKER: J. Rymer — ADDRESS: Rexburg

SYMS - YORK CO., PTRS. & BDRS. 19760

Esp. + mastoid

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 30646
Registered No. 53
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. C. Lauren Hunsaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Student

6. DATE OF BIRTH: July (Month) 29 (Day) 1907 (Year)

7. AGE: 17 yrs. 9 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Smydell Idaho

10. NAME OF FATHER: Joseph E. Hunsaker

11. BIRTHPLACE OF FATHER (State or Country): Arizona

12. MAIDEN NAME OF MOTHER: Jane Hawley

13. BIRTHPLACE OF MOTHER (State or Country): Idaho Falls Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph E Hunsaker
(Address) Rexburg Idaho

15. Filed 5/26 1920 G. D. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. D. Espe M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Rexburg | DATE OF BURIAL: 5/27 1920

20. UNDERTAKER: J. T. Fanning | ADDRESS: Rexburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Madison — Registration District No. 180

City of Teton — Primary Registration District No. 2178

(No. ..... St.)

File No. 30647

Registered No. 5-1

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Ricks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 10 (Day) 18 (Year)

7. AGE: 51 Yrs. 11 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. E. Ricks

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Elizabeth J. Shupe

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. John Ricks

(Address) Teton

15.

Filed 5-5 1920

G. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 4th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 15th 1920 to May 2nd 1920, that I last saw h.IM. alive on May 2nd 1920, and that death occured on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) Yrs. 1 mos. 3 ds.

Contributory (Secondary) Chronic nephritis

(Duration 3 yrs. — mos. — ds.

(Signed) Lorin F. Fick M. D.

5/4 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Teton — DATE OF BURIAL: 5/5 1920

20. UNDERTAKER: John Phillips — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)

File No. 30648
Registered No. 52

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Maria Nielsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Nov. (Month) 17 (Day) 1910 (Year)

7. AGE: 9 Yrs. 5 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Orson P. Nielsen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Matilda Jensen

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Orson P. Nielsen
(Address) Rex. #1

15. Filed 5-18 1920 G. L. Steele Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 16th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16th 1920, to May 16th 1920, that I last saw her alive on May 16th 1920, and that death occured on the date stated above, at 7.20 P. M.

The CAUSE OF DEATH* was as follows:

Cardiac dropsy

(Duration) ..... Yrs. 1 mos. —— ds.

Contributory (Secondary) Mitral insufficiency

(Duration) ..... yrs. 5 mos. —— ds.

(Signed) Lorin F. Rich M. D.

5/17 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 5/18 1920

20. UNDERTAKER: John Phillips — ADDRESS: Rex.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 100
County of Madison Primary Registration District No. 2178
City of Ryley (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 30649
Registered No. 50
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Anderson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Bale

6. DATE OF BIRTH: April (Month) 30 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Babe
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ryley Idaho

10. NAME OF FATHER: Otto E. Anderson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lorette McCarthy

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Otto Anderson
(Address): Thornton

15. Filed 5-4 1920 C. G. Eskelsen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1920, to May 30 1920
that I last saw her alive on May 30 1920
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 4 ds.
Contributory (Secondary): Birth Treasure
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Farley Nelson M. D.
5-3 1920 (Address) Ryburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Ryley — DATE OF BURIAL: 5/4 1920

20. UNDERTAKER: J. W. Young — ADDRESS: Ryley

SYMS - YORK CO., PTRS. & BDRS. 19760

Form U. S. No. 5-25 M. 1-16-18

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30650

Registered No. 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2178

County of Madison

City of Sugar (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Juana Tavarez

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 24th (Day) 1906 (Year)

7. AGE: 13 Yrs. 10 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Schoolgirl & homegirl

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Needles California

10. NAME OF FATHER: Lupeto Tavarez

11. BIRTHPLACE OF FATHER (State or Country): Upper Calenteo Old Mexico

12. MAIDEN NAME OF MOTHER: Norberta Rodriguez

13. BIRTHPLACE OF MOTHER (State or Country): Old Mexico.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernesto Tavarez

(Address) Sugar City, Idaho

15.

Filed May 4 1920

G. G. Eske
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1920 to April 28th 1920, that I last saw her alive on April 28th 1920, and that death occured on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Appendicitis plus Ruptured Appendix

(Duration) Yrs. about mos. ds.

Contributory (Secondary): Peritonitis

(Duration) yrs. mos. 6 ds.

(Signed) George H Mooney M. D.

May 3rd 1920 (Address) Sugar City Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar — DATE OF BURIAL: May 4 1920

20. UNDERTAKER: John Phillips — ADDRESS: Rupert

FORM V. S. No. 5-35 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30652
Registered No. .....

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Fremont
City of Ashton

2. FULL NAME Mildred Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Feb. 2 1910
(Month) (Day) (Year)

7. AGE: 10 Yrs. 3 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business, or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Pete Davis

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ida Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Pete Davis
(Address) Ashton Idaho

15. Filed 2/15 1920. A.M. Meacham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
5 (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/24/1920, to ..... 191..., that I last saw h[illegible] alive on 5/24 1920 and that death occured on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:
Epilepsy
(Duration) 8 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Dest.
X (Duration) X yrs. X mos. X ds.
(Signed) A.M. Meacham M. D.
5/25 1920 (Address) Ashton Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENCE CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho | DATE OF BURIAL ..... 191...

20. UNDERTAKER: Funk Kuser | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STNRS. 24954.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

30653

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 10-2

Primary Registration District No. 6.

File No. 2

Registered No. 4

County of .....

City of .....

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ernest [illegible] Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): [illegible]

6. DATE OF BIRTH. Oct. (Month) 28 (Day) 1886 (Year)

7. AGE: Yrs. 34 Mos. 7 ds. 9

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wayne Neb.

10. NAME OF FATHER: Mike A Connell

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Effie Moore

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ralph Taylor
(Address) Dalton Idaho

15. Filed 6/8/1920. [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) – 6 (Day) – 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920, to June 6 1920, that I last saw h[illegible] alive on June 6 1920 and that death occured on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonic Abscess.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. 3 mos. — ds.

(Signed) [signature] M. D.

6/8 1920 (Address) Dalton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar [illegible] Cemetery | DATE OF BURIAL: June 8 1920

20. UNDERTAKER: [illegible] | ADDRESS: Rupert Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
(No. ....., ... St.)

File No. 30654
Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho
City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Griffin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Unknown (Month) 1 (Day) (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labourer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada Niagara,

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) County Case,
(Address) .....

15.
Filed June 1 1920 G. S. Stockton
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 29 1920, to May 1 1920, that I last saw h[illegible] alive on May 1 1920, and that death occured on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebal Hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio Sclerosis

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

6/2 1920 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: May 1 1920

20. UNDERTAKER: E. S. Hancock — ADDRESS: Grangeville

FORM V. S. No. 5-25 M. 1-16-13.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 30655
Registered No. 17

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosa Neal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
February 5th 1878
(Month) (Day) (Year)

7. AGE
42 Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housework
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Arkansas

10. NAME OF FATHER: John E Lewis

11. BIRTHPLACE OF FATHER: not known
(State or Country)

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER: not known
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lemuel Neal
(Address) Grangeville Idaho

15.
Filed June 1 1920
G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 15th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920, to May 15 1920, that I last saw her alive on May 15 1920, and that death occured on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
acute nephritis

(Duration) 1 Yrs. 1 mos. 16 ds.
Contributory (Secondary) Flu
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.
6/16 1920 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: May 16th 1920

20. UNDERTAKER: E S Hancock
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
(No. .... St.)

File No. 30656
Registered No. 18

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Evans Perkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec (Month) 25 (Day) 1841 (Year)

7. AGE: 78 Yrs. 6 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clinton Co Ohio

10. NAME OF FATHER: John B. Perkins

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Lydia ~~Ford~~ Young

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Grangeville Idaho
(Address) Mrs. Carrie Benedict

15. Filed June 2 1920 G. S. Blocklin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1920, to June 30 1920, that I last saw him alive on May 28 1920 and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Blocklin M. D.

6/31 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View | DATE OF BURIAL: June 1 1920

20. UNDERTAKER: E B Hancock | ADDRESS: Grangeville

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 104
Primary Registration District No.
File No. 30657
Registered No.

1. PLACE OF DEATH
County of Idaho
City of White Bird
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sterling C. Freeman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Nov. (Month) 8 (Day) 1861 (Year)

7. AGE: 58 Yrs. 3 Mos. 25 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter & Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas Mo.

10. NAME OF FATHER: James Freman

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Mary Ann Craft

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. McGaffee
(Address) Riggins - Ida.

15. Filed 19 W. A. Foskett Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar. 1 1920 to April 25 1920 that I last saw him alive on April 24 1920 and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:
Nephritis and Bronchitis following Flue
(Duration) Yrs. 16 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. A. Foskett M. D.
1920 (Address) White Bird

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riggins — DATE OF BURIAL: April 26 1920

20. UNDERTAKER: Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 104
Primary Registration District No.
(No. , St.)

File No. 30658
Registered No.

1. PLACE OF DEATH
County of Idaho
City of Riggins
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Hensley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Jan (Month) 9 (Day) 1858 (Year)

7. AGE: 62 Yrs. — Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Walla Walla Wash

10. NAME OF FATHER: D. W. Hensley

11. BIRTHPLACE OF FATHER (State or Country): Memphis Tenn.

12. MAIDEN NAME OF MOTHER: Rebecca Hobbs

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Charles Hensley
(Address): Riggins - Ida.

15.
Filed 19
W. A. Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1918, to 1920
that I last saw h— alive on — 19—,
and that death occurred on the date stated above, at — M.
The CAUSE OF DEATH* was as follows:
Pernicious Anemia

(Duration) 1 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. A. Foskett M. D.
1920 (Address) White Bird

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riggins Ida. — DATE OF BURIAL: April 13 1920

20. UNDERTAKER: None — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 104
Primary Registration District No.
File No. 30659
Registered No.

1. PLACE OF DEATH
County of Ida
City of White Bird
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Rosbaugh
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
May (Month) 5 (Day) 1844 (Year)

7. AGE
7 Yrs. Mos. 14 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Pittsburgh Pa.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ellen Brown
(Address) White Bird

15. Filed May 1920 W A Foskett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920 to May 19 1920 that I last saw h[illegible] alive on May 15 1920 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Hardened arteries
Sclerosis with
heart-trouble
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Heart —
(Duration) yrs. mos. ds.

(Signed) W A Foskett, M. D.
May 20 1920 (Address) White Bird

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
White Bird	May 2 1920
20. UNDERTAKER Hancock	ADDRESS Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30660
Registered No.

1. PLACE OF DEATH
County of Idaho
City of White Bird
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 104
Primary Registration District No.
(No. St.)

2. FULL NAME Lorin Ellis Adair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Child

6. DATE OF BIRTH
June (Month) 22 (Day) 1915 (Year)

7. AGE
4 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Greer Idaho

10. NAME OF FATHER E. J. Adair

11. BIRTHPLACE OF FATHER (State or Country) Spokane - Wash

12. MAIDEN NAME OF MOTHER Margaret Greer

13. BIRTHPLACE OF MOTHER (State or Country) Greer - Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Adair
(Address) Boles - Ida

15.
Filed 19
W. A. Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 29 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19, to 19,
that I last saw h alive on 19,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:
accidentally shot in face - ball lodged in neck
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. A. Foskett M. D.
19 (Address) White Bird

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	May 31 19 20
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

30661

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 20
Registered No. .....

1. PLACE OF DEATH.

County of Idaho
City of Cottonwood

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME **Rebekah Jane Gillespie,**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: **Female**

4. COLOR OR RACE: **White**

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. **Married** (Write the word.)

6. DATE OF BIRTH. **Dec,** (Month) **22** (Day) 1865 (Year)

7. AGE: **54** Yrs. **5** Mos. **5** ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... **Housewife**

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) **North Corlina**

10. NAME OF FATHER **William Carns**

11. BIRTHPLACE OF FATHER (State or Country) **North Cornlina**

12. MAIDEN NAME OF MOTHER **Martha Lida**

13. BIRTHPLACE OF MOTHER (State or Country) **North Cornlina**

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Floyd Spurgeon

(Address) Deary Ida

15.

Filed May 28 1920 H B Blake Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

May (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated the matter of the death of deceased on May 28 1920 ~~191~~, ~~to~~ ~~191~~, that I last saw h~~e~~ alive on ~~191~~, and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Causes (natural) unknown

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H B Blake M. D.

5/29 1920 (Address) Registrar District 105 Idaho
Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver Ida — DATE OF BURIAL: 5-29 1920

20. UNDERTAKER: J H Mann — ADDRESS: Cottonwood Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

30662

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 165
Primary Registration District No. 2183
File No. 17
Registered No.

1. PLACE OF DEATH
County of Idaho
City of Cottonwood (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Raymond Foster McClintock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 11 (Day) 1911 (Year)

7. AGE: 8 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo. McClintock

11. BIRTHPLACE OF FATHER (State or Country): Calif.

12. MAIDEN NAME OF MOTHER: Mae Hammond

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. McClintock
(Address) Cottonwood Idaho

15. Filed May 7th 1920 W. W. Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1920, to May 6 1920, that I last saw him alive on May 6 1920, and that death occured on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:
Diffuse peritonitis following acute attack of Appendicitis with rupture of Appendix. Drainage produced
(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) —
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wesley F. Orr M. D.
5/7 1920 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow Ida. DATE OF BURIAL: 5-9 1920

20. UNDERTAKER: J. A. Nau ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BKRS.

FORM V. S. No. 5-25 M. 1-16-13

30663

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)
File No. 18
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Cottonwood
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Crosby

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
May (Month) 23 (Day) 1920 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..2.. hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Enoch E Crosby

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary Kopczynski

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Enoch E Crosby
(Address) Cottonwood Idaho

15.
Filed May 23 1920
W N Burke
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1920, 4 p.m. to May 23 1920, 6 a.m., that I last saw her alive on May 23 1920, and that death occured on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:
Premature Birth. Gestation 7 months.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Wesley F. Orr M. D.
5/28 1920 (Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cottonwood Ida	May 25 1920
20. UNDERTAKER	ADDRESS
Enoch E Crosby	Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

30664

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 19

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Cottonwood

(No. ....., ... St.)

Registration District No. 105

Primary Registration District No. 2183

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Crosby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 23 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 10 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Enoch E Crosby

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary Kopczynski

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Enoch E Crosby

(Address) Cottonwood Idaho

15.

Filed May 23 1920

H B Blake
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1920, to May 23 1920, that I last saw her alive on May 23 1920, and that death occured on the date stated above, at 4 30 M.

The CAUSE OF DEATH* was as follows:

Premature Birth - Section
7 Months

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

5/28 1920 (Signed) Wesley F. Carr M. D.

(Address) Cottonwood Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Ida — DATE OF BURIAL: May 23 1920

20. UNDERTAKER: Enoch E Crosby — ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30665

Registered No. 92

1. PLACE OF DEATH.

County of Idaho

City of Stites

Registration District No. 106

Primary Registration District No. 2184

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Ellenwood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. November (Month) 25 (Day) 1905 (Year)

7. AGE: 14 Yrs. 5 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a). Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ernest Ellenwood

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Martha Morrise

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jesse Williams

(Address) Stites Ida.

15. Filed May 20 1920 J M Rubenkenes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1920, to May 12 1920, that I last saw h[illegible] alive on May 7 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J M Rubenkenes M. D.

May 13 1920 (Address) Kooskia Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Judicial County Stites — DATE OF BURIAL: May 14 1920

20. UNDERTAKER: Geo Feeney — ADDRESS: Kooskia Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVIS - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30667

Registered No. 90

Registration District No. 106

Primary Registration District No. 2184

(No. ..... St.)

1. PLACE OF DEATH.

County of Idaho

City of States

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Flora E. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 5th (Day) 1862 (Year)

7. AGE: 57 Yrs. 6 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Jonathan McCammond

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Blystone

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Myrtle Yarbrough
(Address) States Idaho

15. Filed May 20 1920

J. M. Verbeckmans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 7th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1920, to May 7 1920, that I last saw h SW alive on May 7 1920, and that death occured on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Chronic Bright's - Uraemic Poisoning High blood pressure Heart failure

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H W Wentworth M. D.

May 10 20 (Address) States Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: States Ida — DATE OF BURIAL: May 191

20. UNDERTAKER: Geo Tierney — ADDRESS: Rooskia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SONS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 30668
Registered No. 93

1. PLACE OF DEATH.
County of Idaho
City of Stites
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard William Blewett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Widowed

6. DATE OF BIRTH. May (Month) 26 (Day) 841 (Year)

7. AGE: 79 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Blewitt

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gilbert Blewett
(Address) Stites Idaho

15. Filed May 24 1920 J M Weberkeuse Local Registrar

EVANS - YORK CO., PTRS. & BOOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1, 1920, to May 24 1920, that I last saw him alive on May 22 1920, and that death occured on the date stated above, at 4:15a M.

The CAUSE OF DEATH* was as follows:
Heart failure - edema legs abdomen - Gangrene legs

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H W Wentworth M. D.
May 24 1920 (Address) Stites Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gifford Ida — DATE OF BURIAL: 191

20. UNDERTAKER: Geo Tennant — ADDRESS: Kooskia

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

30669

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 3
Registered No. 30

1. PLACE OF DEATH.
County of Bingham
City of Sterling
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Westley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May 18 1920
(Month) (Day) (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or 40 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clarence H. Westley

11. BIRTHPLACE OF FATHER (State or Country): Nevada

12. MAIDEN NAME OF MOTHER: Viola Una Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. H. Westley
(Address) Sterling Ida

15. Filed May 19 1920 mcmenkinnon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 18 1920
(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 1920, to May 18 1920 that I last saw h[e] alive on May 18 1920 and that death occured on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH* was as follows:
atelectasis
a small poorly developed baby
Congenital
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) mcmenkinnon M. D.
May 18 1920 (Address) Henderson Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days
In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Good Cemetery Henderson Ida
DATE OF BURIAL: May 21 1920

20. UNDERTAKER: Friends
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOLS. 24653

FORM V. S. No. 5-25 M. 1-16-13

30670

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 3
Registered No. 31

1. PLACE OF DEATH.
County of Bingham
City of Sterling
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Westley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May 18 (Month) 20 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ... 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clarence H Westley

11. BIRTHPLACE OF FATHER (State or Country): Nevada

12. MAIDEN NAME OF MOTHER: Viola Mae Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. H. Westley
(Address) Sterling Ida

15. Filed May 19 20 1919 Mcmenamins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May 18 20 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18 20 191, to May 18 20 191, that I last saw h[im] alive on May 18 20 191, and that death occured on the date stated above, at 12-10 P.M.

The CAUSE OF DEATH* was as follows:
marasmus,
a small poorly developed baby, Congenital
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. McMenamins M. D.
5/19 1920 (Address) Sterling Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I. O. O. F. Cemetery Sterling — DATE OF BURIAL: May 21 191 20

20. UNDERTAKER: Friends — ADDRESS

BYRNE - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 30671

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2185
(No. ....., ... St.)

File No. 3
Registered No. 32

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Barton Shatton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sept (Month) ..... (Day) 1857 (Year)

7. AGE: 62 Yrs. 8 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James Shatton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Janis Clark

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P. L. Shatton
(Address) Aberdeen Ida

15. Filed May 22 20 191 M. C. MacKinnon
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 21 20 191
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Ap 15 20 191..., to May 21 20 191..., that I last saw him alive on May 21 20 191..., and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) Yrs. 1 mos. 7 ds.
Contributory (Secondary) Hypostatic Pneumonia
(Duration yrs. mos. 3 ds.

(Signed) M. C. MacKinnon M. D.
5/22 20 19... (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Provo Utah
DATE OF BURIAL: May 24 20 191

20. UNDERTAKER: E T Peck
ADDRESS: Blackfoot Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30673
Registered No. 425

Registration District No. 117
Primary Registration District No. 2196
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 7 (Day) 1839 (Year)

7. AGE: 80 Yrs. 10 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: — Gustafson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Katrina —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Peter Nelene
(Address): Burley

15. Filed 6-4-20 1920 J. S. Pattrea
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920 to June 3 1920
that I last saw her alive on June 2 1920
and that death occurred on the date stated above, at .... M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 20 Yrs. — mos. — ds.

Contributory (Secondary) — (Duration) — Yrs. — mos. — ds.

(Signed) R. T. Kearsley M. D.

1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenley — DATE OF BURIAL: June 4 1920

20. UNDERTAKER: R. H. Watt — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

Patterson.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30674

Registered No. 426

1. PLACE OF DEATH.

Registration District No. 117

Primary Registration District No. 2196

County of Cassia

City of Burley

(No. 304 So. Hanson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ross M. Spray.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 19 (Day) 1916 (Year)

7. AGE: 3 Yrs. 10 Mos. ——— ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: Robert T. Spray.

11. BIRTHPLACE OF FATHER (State or Country): Tooele Utah.

12. MAIDEN NAME OF MOTHER: Vera M. Martindale.

13. BIRTHPLACE OF MOTHER (State or Country): Oakley Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert T. Spray.

(Address) 304 So. Hanson.

15.

Filed May 20 1920

Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May. (Month) 19. (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1920, to May 19 1920, that I last saw him alive on May 19 1920, and that death occured on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

acute suffurative Encephalitis

(Duration) Yrs. mos. 12. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) J. C. Patterson M. D.

5-20 1920 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Ida. DATE OF BURIAL: May 21 1920

20. UNDERTAKER: L. B. Talloogy ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

Cooper.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30675

Registered No. 427

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Cassia.

City of Burley.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 2196

(No. ....., North Normal Ave., St.)

2. FULL NAME Doras Jensen.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 1st (Day) 1920. (Year)

7. AGE: 00 Yrs. 1 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... At home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Everett Jensen.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Marintha Jorgensen

13. BIRTHPLACE OF MOTHER (State or Country) Utah Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C. E. Jensen

(Address) Box 44 Burley Ida.

15. Filed April 8 1920 P. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2. 1920. to April 7. 1920, that I last saw him alive on April 7 - 1920, and that death occured on the date stated above, at 6.15 A.M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis.

..... (Duration) Days Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Cooper M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: 4/8/1920

20. UNDERTAKER: L. D. Talleyg. ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30576

Registered No. 66

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 121

Primary Registration District No. 2194

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Polly Mae Frazier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 23 (Day) 1920 (Year)

7. AGE ..... Yrs. 3 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Robert Frazier

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Belle Bentley

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Russell Bentley

(Address) Moreland Idaho

15. Filed May 6 1920 Mrs Nalen E. Petrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 5 (Day) 1920 (Year)

17. I ~~HEREBY~~ CERTIFY, That I ~~attended deceased from~~ Investigated ~~last~~ 191..., to ..... 191...,

~~that I last saw h... alive on ..... 191...~~,

and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows: Pneumonia - Bronco

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Petrie M. D.

(Address) Blackfoot Idaho County Bingham

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland — DATE OF BURIAL: May 6 1920

20. UNDERTAKER: Russell Bentley — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 171
Primary Registration District No. 7-9-7
File No. 30677
Registered No. 9

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Alma Richmond

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
April 28 (Month) (Day) 1879 (Year)

7. AGE
40 Yrs. ..... Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farming
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Ernest Richmond

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Carter Sey

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Laura M. Richmond
(Address) Blackfoot Ida

15.
Filed May 10 1920 Mrs Laura M. Richmond
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 6 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Immediate Cause 19....., that I last saw h... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Struck by Lightning

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E J Funk M. D.
5/10 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grove Cem Canon	5-11 1920

20. UNDERTAKER E J Funk — ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 131

Primary Registration District No. 1017

File No. 30678

County of Bingham

City of Blackfoot (No. ....., ... St.)

Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Arthur Rumble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 1 (Day) 1907 (Year)

7. AGE: 12 Yrs. 11 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Ida

10. NAME OF FATHER: A C Rumble

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Rose Nothdurft

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A C Rumble
(Address) Black Foot

15. Filed 5-11 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920 to May 10 1920, that I last saw h[illegible] alive on May 10 1920, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Mytral Insufficiency
Valvular Disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.

5/11 1920 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferm City Cemetery — DATE OF BURIAL: 5/12 1920

20. UNDERTAKER: E Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30679
Registered No. 69

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle E. Sullivan

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: 5 (Month) 18 (Day) 1920 (Year)

7. AGE: 21 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Hunt

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Arbie Mace Norton

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) as shown by Certificate
(Address) Blackfoot, Ida

15. Filed May 19 1920 Mrs Hale E. Taylor Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1920 to May 18 1920 that I last saw h[er] alive on May 18 1920 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
General Exhaustion of
acute Mania

..... (Duration) ..... yrs. 18 mos. ..... ds.
Contributory (Secondary): Auto Infection
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. V. Lowry M. D.
5.19 1920 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death Insane Asylum ..... yrs ..... mos ..... ds. In the State Blackfoot ..... yrs 7 mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence Pocatello, Ida

19. PLACE OF BURIAL OR REMOVAL: Lake Idaho
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: C. J. Peck
ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot, Ida
(No. ....., ... St.)

Registration District No. 121
Primary Registration District No. 2194

File No. 30680
Registered No. 78

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Willis McMullin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH: March (Month) 26 (Day) 1844 (Year)
7. AGE: 76 yrs. 11 mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: Don't Know
11. BIRTHPLACE OF FATHER (State or Country): Don't Know
12. MAIDEN NAME OF MOTHER: Don't Know
13. BIRTHPLACE OF MOTHER (State or Country): Don't Know
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Records of Idaho Insane Asylum
(Address) by Robert Kring
15.
Filed May 28 1920 Mrs Nalin E. Cabell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 4 1920, to May 27 1920
that I last saw him alive on May 27 1920
and that death occurred on the date stated above, at 5:30 a.M.
The CAUSE OF DEATH* was as follows:
General debility caused by senility.
(Duration) 6 yrs. — mos. — ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. A. Horn M. D.
May 27 1920 (Address) Blackfoot, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 3 mos. 23 ds. In the State 20 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence: Sterling, Idaho

19. PLACE OF REMOVAL: E. J. Peck Funeral Parlors
DATE OF BURIAL: May 28 1920
20. UNDERTAKER: E J Fisk
ADDRESS: Blackfoot

AYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

CERTIFICATE OF DEATH

Registration District No. 121

County of Bingham Primary Registration District No. 2194

City of Blackfoot (No. ....., ... St.)

File No. 30081

Registered No. 71

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Stevens

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: 5 (Month) 29 (Day) 1855 (Year)

7. AGE: 65 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Pharmacist
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Can't say

11. BIRTHPLACE OF FATHER (State or Country): Can't say

12. MAIDEN NAME OF MOTHER: Can't say

13. BIRTHPLACE OF MOTHER (State or Country): Can't say

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Institution Records
(Address) C. A. Hoover, Med. Supt.

15. Filed 6-2 1920 Nora Nalen E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 5 (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 12 1919, to May 29 1920 that I last saw h[illegible]alive on May 29 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

Sudden

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Previous Cerebral Hemorrhages and general Paralysis

(Duration) 3 yrs. 6 mos. ..... ds.

(Signed) C. A. Hoover M. D.

6/2 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... / yrs. 6 mos. 28 ds. In the State Insane Asylum State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt. View Idaho

DATE OF BURIAL: ..... 191...

20. UNDERTAKER: E J Funk

ADDRESS: Blackfoot

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30682 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 127
County of Shoshone
Primary Registration District No. 2200
City of Tamarack Mine (No. Residence) St. Tamarack
File No. Mine 39
Registered No.
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Franklin Zadell
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	Single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank Zadell

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Edna Sheldon

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Zadell
(Address) Wallace Ida Tamarack

15.
Filed May 11 1917 H. C. Mowery
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11, 1920 to May 11 1920
that I last saw h-- alive on May 11 1920
and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Premature birth
(Duration) yrs. mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.
(Signed) Dr. Mowery M. D.
May 11 1920 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days.
Where was disease contracted if not at place of death?
Former or usual residence none

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida | DATE OF BURIAL: May 12 1920

20. UNDERTAKER: Harry Thompson | ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

30683

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 12

Primary Registration District No. 1200

(No. Marsh Mine Bunk) House

File No.

Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Adrian Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Nov. (Month) 10th (Day) 1864 (Year)

7. AGE 55 Yrs. 6 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: miner

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER — Johnson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary Swild

(Address) Burke Ida

15. Filed May 14 1920 — Mowry, Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Overcome with gas

Was dead when brought

out of mine.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

5/17 1920 (Signed) K B Hockaday M. D.

(Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Idaho	May 17 1920

20. UNDERTAKER C. C. Mortell — ADDRESS Wallace Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 122

Primary Registration District No. 222

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30684

Registered No. 41

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No.) March Mine Burke

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick Bergen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. April 30 (Month) (Day) 1 (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Ernst Kroon

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. O. Bergen

(Address) Wallace Ida.

15. Filed May 14 1920

L. C. Moore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Carcinoma mitis ovary, five mos

Diagnosis made when brought to hospital

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) L B Stockbridge M. D.

5/17 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos...days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash | DATE OF BURIAL: May 1920

20. UNDERTAKER: B E Worstell | ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Shoshone

City of Wallace

(No. Marsh Mine Burke)

Registration District No. 82

Primary Registration District No. 2200

File No. 30685

Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Conley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. May (Month) 5 (Day) 1884 (Year)

7. AGE 36 Yrs. 0 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... miner

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Wm Conley

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Edna Burns

13. BIRTHPLACE OF MOTHER (State or Country) Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Owen Conley

(Address) Kellandale Wash.

15. Filed May 14 1920

H C Mowry
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...; that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Overcome by gas fire
room Shaft, Dead
when brought to surface

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L B Hendricks M. D.

5/18 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace Ida — DATE OF BURIAL May 17 1920

20. UNDERTAKER R D Worstell — ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30686
Registered No. 43

Registration District No. 1722
Primary Registration District No. 2209

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Burke Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victor Simpson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
November (Month) 26 (Day) 1874 (Year)

7. AGE: 46 Yrs. 5 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: Simeon Sampson

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Aga Roku

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ed. Simonson
(Address) Burke Ida.

15. Filed May 21 1920 H. C. Mowery Local Registrar

SYMS - YORK CO., PTRS. & STNR. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1916, to May 21 1920, that I last saw him alive on May 15 1920, and that death occured on the date stated above, at 11a M.

The CAUSE OF DEATH* was as follows:
Suffocation following apoplectic attack

(Duration) 6 Yrs. — mos. — ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. A. Dittman M. D.
May 21 1920 (Address) Burke Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: May 25 1920

20. UNDERTAKER: R. C. Barstell
ADDRESS: Wallace

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 124
Primary Registration District No. 2406
File No. 30687
Registered No. 44

1. PLACE OF DEATH.
County of Shoshone
~~City~~ of Cabour (No. Residence St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alba Branchi.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: May (Month) 26 (Day) 1900 (Year)

7. AGE: ....yrs. ....mos. 20 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Branchi

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Teresina Ricci

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Branchi
(Address) Cabour Idaho.

15. Filed May 27 1920 H. C. Mower Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920, to May 26 1920
that I last saw her alive on May 25 1920
and that death occurred on the date stated above, at 7P M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ....yrs. ....mos. 5 ds.
Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.
(Signed) Dr Mower M. D.
May 27 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days.
Where was disease contracted if not at place of death?
Former or usual residence: Cabour Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida | DATE OF BURIAL: May 27th 1920

20. UNDERTAKER: Stacy Thompson | ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12 a
Primary Registration District No. 2100
File No. 30688
Registered No. 45

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Burke St.) (Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jr. Joseph Hennessy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. November 10th 1 (Month) (Day) (Year)
7. AGE: 55 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Wisconsin
10. NAME OF FATHER: John H Hennessy
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER: Mary McHughes
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J J Hennessy
(Address) Burke Ida.
15. Filed May 27/ 1920 H C Mackey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 23 1920, to May 27 1920, that I last saw h alive on May 27 1920, and that death occured on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
followed by Acute Bright's disease
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) L B Blackadar M. D.
May 28 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191.....

20. UNDERTAKER: Bruce G. Mordell | ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24853

Form V. S. No. 5 20M.1-16-12

17

CERTIFICATE OF DEATH

30689

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1201
Primary Registration District No. 123
(No. ..., ... St.)

File No. 77
Registered No. ...
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Reuben Riley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 16 (Day) 1893 (Year)

7. AGE: 17 yrs. 2 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoolboy
(b) General nature of industry business, or dstablishment in which employed (or employer): 1

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Reuben Riley

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Rena Maynard

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Reuben Riley
(Address) ...

15. Filed 5/7/ 1920 Geo. L. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 31th 1920, to May 11th 1920, that I last saw him alive on May 10th 1920, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Gun shot wounds.

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) W. C. Sunday M. D.
5/15 1920 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Kellogg — DATE OF BURIAL: May 14 1920

20. UNDERTAKER: M. S. Thomlick — ADDRESS: Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30690 State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 173

County of Shoshone Primary Registration District No. 1701 File No. 76

City of Kellogg (No. 2, St.) Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carlo Juanti

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH February 6 1915
(Month) (Day) (Year)

7. AGE 2 yrs. 2 mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Cas Juanti

11. BIRTHPLACE OF FATHER (State or Country) Finland

12. MAIDEN NAME OF MOTHER Hilma Juanti

13. BIRTHPLACE OF MOTHER (State or Country) Finlat

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cas Juanti
(Address) Kingston, Ida.

15. Filed 6/27 1917 Jos. D. Leiber Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Apr 26 1917
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Unknown.

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. L. Lawson M. D.
5/27 1917 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Mt. Ste Cemetery Kingston Ida. DATE OF BURIAL: Apr 29 1917

20. UNDERTAKER: M C Shanklin ADDRESS: Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30691

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 7101
(No. ..., ... St.)

File No. 75
Registered No. ...
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward M. Chilton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	Wht	Married

6. DATE OF BIRTH
Dec 21 1
(Month) (Day) (Year)

7. AGE
40 yrs. ... mos. ... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Electrician
(b) General nature of industry business, or dstablishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER James Green Chilton

11. BIRTHPLACE OF FATHER (State or Country) Arkansas

12. MAIDEN NAME OF MOTHER Miss Clifton

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. W. Chilton
(Address) Kellogg Idaho

15. Filed 5/15 1920 Geo. S. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 14 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9 1920, to May 13 1920, that I last saw him alive on May 13 1920 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Burn, caused by 60000 volt current.

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. F. Kennedy M. D.
May 15 1920 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF ~~BURIAL~~ OR REMOVAL	DATE OF BURIAL
Tekoa, Wash	...191...

20. UNDERTAKER	ADDRESS
M. C. Thorsville	Kellogg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30692

Lindsay

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 123

County of Shoshone

Primary Registration District No. 2701

File No. 24

City of Kellogg

(No. 0, St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lenay R. Nash

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 21 (Day) 1884 (Year)

7. AGE: 35 yrs. 6 mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: A C Nash

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Miss Kirk

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs B. Nash
(Address) Butte, Montana

15. Filed 5/26 1920 Geo. S Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 21, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5th 191 , to May 21 1920
that I last saw him alive on May 21 1920
and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Spinal Meningitis

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M Lindsay M. D.
5/27 1920 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Frontdale, Va — DATE OF BURIAL: May 27, 1920

20. UNDERTAKER: M C Thornhill — ADDRESS: Kellogg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30693 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 7201
(No. ....., ... St.)

File No. 23
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank E McDonald

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March (Month) 24 (Day), 1888 (Year)

7. AGE: 32 yrs. 1 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: D. N. McDonald

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Davis

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. N. McDonald
(Address) Mead, Wash.

15. Filed 5/11 1920 Geo S Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Electrocuted

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. S. Lesher, Coroner M. D.
5/11 1920 (Address) Kellogg

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Spokane | DATE OF BURIAL: May 13 1920

20. UNDERTAKER: W. C. Thornhill | ADDRESS: Kellogg

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30695
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. 2 3
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mabel Saunders.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Aug 16 1914
(Month) (Day) (Year)

7. AGE
5 Yrs. 6 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER: B.B.Saunders

11. BIRTHPLACE OF FATHER
(State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Ellie Suckau

13. BIRTHPLACE OF MOTHER
(State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15.
Filed Feb. 10 191 Alice A Dutton
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb. 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 17 1920, to Feb. 8 1920, that I last saw her alive on Feb. 8 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobular
Bronchial
(Duration) ..... Yrs. ..... mos. 22 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. 2 ds.
(Signed) Hallett Mayl M. D.
Feb 9 1920 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian
DATE OF BURIAL: 10 191 20

20. UNDERTAKER: W S Coates
ADDRESS: Meridian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 20678
Registered No.

1. PLACE OF DEATH

County of Boise

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 12 mi east of Horseshoe Bend St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Phoebe J. Ireton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Married

6. DATE OF BIRTH: Sept 21 1848 (Month) (Day) (Year)

7. AGE: 71 Yrs. 3 Mos. 15 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Aaron Warner

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Hilda Fuller

13. BIRTHPLACE OF MOTHER (State or Country): Connecticut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J.A. Ireton
(Address) Boise, Idaho.

15.
Filed 19
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan 5 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1919, to Dec 28 1919, that I last saw h alive on Dec 28 1919, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) Yrs. mos. ds.

Contributory (Secondary) Valvular heart

(Duration) yrs. mos. ds.

(Signed) E.S. Fitch M. D.

19 (Address) Gooding Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Jan 8 1920
20. UNDERTAKER	**ADDRESS**
Summers & Krebs	Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2130
(No. Shelton Ida, St.)

File No. 30699
Registered No. 99

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls Co.

2. FULL NAME Mariah Downs.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 4 (Day) 1882 (Year)

7. AGE: 38 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Jno Downs.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Conway

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L. Howard
(Address) Shelton Ida.

15. Filed July 12 1920 Wm Timmond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nuch (Month) 24 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,
that I last saw h..... alive on ....., 19.....,
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Cirhosis
No medical attendance

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm Timmond - Local M. D.
7/12 1920 (Address) Local Falls Register #73

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shelton Ida — DATE OF BURIAL: June 26 1920.

20. UNDERTAKER: Steffens — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Calloway.

FORM V. S. No. 5-25 M. 1-19.

(20)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30700
Registered No. 204

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 410 W State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha L Sommerville

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: Jan (Month) 10 (Day) 1855 (Year)

7. AGE: 65 Yrs. 4 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L. Sommerville
(Address) Boise Idaho.

15. Filed June 1 1920 L. P. Duncan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 21 1920, to May 31 1920
that I last saw h.r alive on May 30 1920
and that death occurred on the date stated above, at 1 A M.
The CAUSE OF DEATH* was as follows:
Cancer of Stomach
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. Allen Calloway M. D.
5-31 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: June 2 1920

20. UNDERTAKER: Summers & Fobs. | ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS
the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement
of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

State of [illegible]
BOARD OF [illegible]
Bureau of Vital [illegible]

1. PLACE OF DEATH.

Registration District No. 2

Primary Registration District No. 1004

File No. 30701

County of Ada

City of Boise (No. 3116 Leroy St.)

Registered No. 205

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Louisa Hugyman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan (Month) 10 (Day) 1874 (Year)

7. AGE: 46 Yrs. 4 Mos. ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lenbard Ill

10. NAME OF FATHER: Willard O. Hart

11. BIRTHPLACE OF FATHER (State or Country): N. York

12. MAIDEN NAME OF MOTHER: Martha Jane Lucas

13. BIRTHPLACE OF MOTHER (State or Country): N. York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Louis Edward Hugyman

(Address) Boise

Filed Jun 1 1920

L. P. Forman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 13 1920, to May 28 1920, that I last saw h[illegible] alive on May 27 1920, and that death occured on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Asthma

(Duration) 2 yrs. mos. ds.

(Signed) R E Blunt M. D.

May 27 1920 (Address) Boise Ida

State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/1 1920

20. UNDERTAKER: Schneider & Liedenfader — ADDRESS: Boise

[illegible] WORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 3076
Registered No. 207

1. PLACE OF DEATH
County of Ada
City of Boise
(No. rear of 115 Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James G. Kennedy
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE: About 65 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lawyer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: James G. Kennedy

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Katherine E. McLene

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs J. R. Russell
(Address): Kingman

15. Filed June 2 1920 Ariz
Local Registrar L. P. Thomas

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 24½ 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1920 to May 24½ 1920
that I last saw h. alive on May 24½ 1920
and that death occurred on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) John Davis M. D.
May 30 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/3 1920

20. UNDERTAKER: Schreiber & Siebenpfeiffer — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30704
Registered No. 208

Registration District No. 2
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada
City of Boise (No. 1416 Jefferson St.)

2. FULL NAME Abraham Zehner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH December 5th 1839
(Month) (Day) (Year)

7. AGE 81 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Penn.

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) America

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carrie E. Myers.
(Address) San Francisco Calif.

15. Filed June 2 1920 L. P. Inman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1920 to June 1 1920 that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Paralysis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Antrobus M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Masonic Cemetery **DATE OF BURIAL** 6/2 1920

20. UNDERTAKER Schreiber & Hickenfoden **ADDRESS** Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 16th 1004
File No. 30705
Registered No. 209

1. PLACE OF DEATH
County of Ada.
City of Boise.
(No. 915 - N. 16th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wesley Eckert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: — (Month) — (Day) 1848 (Year)

7. AGE: 72 Yrs. — Mos. — ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Photographer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: John J. Eckert

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Hulda Crosby

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise, Idaho.

15. Filed June 2 - 1920 L. D. Oman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May - 30 - 1920 (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1920, to May 30 1920 that I last saw him alive on May 30 1920, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Endocarditis
?
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) [illegible] M. D.
6/2 1920 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: 6 - 3 1920

20. UNDERTAKER: Wm McBratney
ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30766
Registered No. 210

1. PLACE OF DEATH

County of Ada

City of Boise (No. 418 Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

2. FULL NAME Evelyn O'Farrell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED single (Write the word.)

6. DATE OF BIRTH November (Month) 25 (Day) 1875 (Year)

7. AGE 45 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Boise

10. NAME OF FATHER John a. O'Farrell

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Anne Chapman

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Theresa O'Farrell

(Address) 418 Franklin, Boise

15. Filed June 3 1920 L. D. Gemmell Local Registrar

KYNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1919, to April 1920 that I last saw h er alive on April 1920 and that death occurred on the date stated above, at A M.

The CAUSE OF DEATH* was as follows:

Chronic mitral valve lesion

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Spanish Flu.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. V. Geneva, M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL St Johns Cemetery — **DATE OF BURIAL** 6/4 1920

20. UNDERTAKER Schreiber & Heidenfelder — **ADDRESS** Boise

FORM V. S. No. 5-25 M. 1-19.

Springer.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30707
Registered No. 211

1. PLACE OF DEATH
County of Ada
City of Boise
(No. St Lukes Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maudes J. Cole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Wid.)

6. DATE OF BIRTH: Feb 20 (Month) (Day) 1885 (Year)

7. AGE: 35 Yrs. 3 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: John T. Hoff.

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Marie Elking.

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. Cole
(Address) 1613 N 16

15. Filed June 3 1920 L. O. Inman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 3 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1920 to June 3 1920 that I last saw h. alive on June 3 1920 and that death occurred on the date stated above, at 6:10 A M.

The CAUSE OF DEATH* was as follows:
Cerebral Embolis.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Caesarian section.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J A Springer M. D.
June 3 1920 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dalton Mem. | DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: Summers & Hobbs. | ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30708

Registered No. 213

1. **PLACE OF DEATH**

County of Ada

City of Boise

(No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** George H. Zimmerman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: M

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Married

6. **DATE OF BIRTH**: Aug (Month) 8 (Day) 1873 (Year) 1873.

7. **AGE**: 46 Yrs. 9 Mos. 25 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Attorney

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Ill.

10. **NAME OF FATHER**: Jacob Zimmerman

11. **BIRTHPLACE OF FATHER** (State or Country): Germany

12. **MAIDEN NAME OF MOTHER**: Anna Hummel

13. **BIRTHPLACE OF MOTHER** (State or Country): Germany

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Anna Zimmerman

(Address) Emmett Ida Co.

15. Filed 6/4 1920 A. C. Forman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: 6 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/8 1920 to 6/3 1920 that I last saw h[illegible] alive on 6/3 1920 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Tabo-Paresis

(Duration) Yrs. mos. ds.

Contributory (Secondary) Hodgkins

(Duration) yrs. mos. ds.

(Signed) Fred. A. Tuthill M. D.

6/4 1920 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Emmett Ida Co.

DATE OF BURIAL: June 6 1920

20. **UNDERTAKER**: Simmons & Webb

ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30709

Registered No. 214

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 410 State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Klient

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 27th 1920 (Month) (Day) (Year)

7. AGE: ____ Yrs. ____ Mos. 7 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: Richard Klient

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Lydia Schubert

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. A. Schubert

(Address)

15. Filed 6/6 1920 A. D. Furman Local Registrar

Mc. C. Ida.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 4th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1920, to June 4 1920 that I last saw her alive on June 4 1920 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Pneumatus baby, only 7 mos. only lived 8 days

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) Anaemia of mother

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. W. Calls M. D.

6/6 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

St. Alphonsus Hospital

Where was disease contracted if not at place of death?

Former or usual residence S

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/5 1920

20. UNDERTAKER: Schreiber & Siderfaden — ADDRESS: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30710
Registered No. 516

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 709 Warm Springs St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emelia R. Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Mar (Month) 13th (Day) 1839 (Year)

7. AGE: 81 Yrs. 2 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Leipzig. Germany

10. NAME OF FATHER: Fred Wm Rümpler

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Maria H. E. Liederitz

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Siedenfaden
(Address) Boise, Ida.

15. Filed 6/3 1920 A. B. Morman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1920 to June 2 1920 that I last saw h.. alive on June 2 1920 and that death occurred on the date stated above, at 2 30 P.M.

The CAUSE OF DEATH* was as follows:
angina Pectoris

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio-Sclerosis
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. D. Springer M. D.
June 4 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/ 1920

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30711
Registered No. 217

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Gunn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 16 (Day) 1873 (Year)

7. AGE: 46 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Not obtainable

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Mary Gunn Richfield

15. Filed 6/6 1920 L. Thoman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1920, to 5/5 1920 that I last saw him alive on 5/5 1920 and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema

(Duration) ... Yrs. ... mos. 10 ds.

Contributory (Secondary) Tuberculosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) A. L. Kleine M. D.

5/5 1920 (Address) Boise Ada

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence Richfield, Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 6/7 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30712

Registered No. 218

1. **PLACE OF DEATH**

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1506 N. 17 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Mary Hamilton

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: F

4. **COLOR OR RACE**: W

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Widow

6. **DATE OF BIRTH**: April (Month) 30 (Day) 1839 (Year)

7. **AGE**: 81 Yrs. 1 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Penn

10. **NAME OF FATHER**: John Brenton

11. **BIRTHPLACE OF FATHER** (State or Country): Penn

12. **MAIDEN NAME OF MOTHER**: Unknown

13. **BIRTHPLACE OF MOTHER** (State or Country): Unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) R B Jordan

(Address) Nampa Ida

15. Filed June 7 1920 L. R. Oman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: June (Month) 5th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2nd 1920 to June 5th 1920 that I last saw h.. alive on June 5th 1920, and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy —

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Baeck M. D.

6-7 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Riverdale, Wash. | **DATE OF BURIAL**: June 9 1920

20. **UNDERTAKER**: Hummer & Hale | **ADDRESS**: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30713

Registration District No. 8
Primary Registration District No. 1004
Registered No. 219

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 112, E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm. H. Tatro

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH 1860 (Month) (Day) (Year)

7. AGE 60 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) N. Y.

10. NAME OF FATHER ~~Not~~ Dont Know

11. BIRTHPLACE OF FATHER (State or Country) Dont Know

12. MAIDEN NAME OF MOTHER Dont Know

13. BIRTHPLACE OF MOTHER (State or Country) Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Mae
(Address) St Lukes Hospt

15. Filed June 8 1920 L. P. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 6th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24 1920 to June 6 1920 that I last saw h[illegible] alive on June 8th 1920 and that death occurred on the date stated above, at 2.25 A.M.

The CAUSE OF DEATH* was as follows:
Spotted Fever
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J S Springer M. D.
June 7 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Mayfield Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	6/9 1920

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30714

Registered No. 220

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 104

(No. 2222 Harrison Blvd. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Elizabeth Shanks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Sept. 17 — 1845 (Month) (Day) (Year)

7. AGE: 74 Yrs. 8 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Matthew P. Valley.

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Don't Know.

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) D. E. Shanks.

(Address) Boise Ida.

15. Filed June 9 1920 L. O. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 8 — 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6th 1920 to June 8th 1920 that I last saw h.r. alive on June 7th 1920 and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Gangreane of foot

(Duration) ..... Yrs. ..... mos. 2/ ds.

Contributory (Secondary) arthritis deformans

(Duration) 18 yrs. ..... mos. ..... ds.

(Signed) L. E. Broom M. D.

6-8 1920. (Address) Boise, Idah.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elmer. Missouri — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Wm McBratney — ADDRESS: Boise Idaho.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30715

Registered No. 221

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Archey L. Levy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 15th (Day) 1895 (Year)

7. AGE: 24 Yrs. 5 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City, Utah

10. NAME OF FATHER: Isreal Levy

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Ida F. Josephson

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) I. Levy.

(Address) Caldwell Ida

15. Filed Jun 10 1920

L. P. Quman
Local Registrar

Dr. Heine

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8 1920, to June 9 1920 that I last saw h.im alive on " " 1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acute dilatation heart.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Infected tonsils

(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) A. L. Heine M. D.

6/10 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Caldwell, Idaho

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Ut. DATE OF BURIAL: 6/10 1920

20. UNDERTAKER: Schreiber & Siebenfaden ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30716
Registered No. 224

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 114, East Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Melvin Smart
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: August 11 1842 (Month) (Day) (Year)

7. AGE: 77 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many ... hr. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer): Land Rancher

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Chas Smart

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Susan Smith

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Smart
(Address) Bliss el Idaho.

15. Filed June 14 1920 L. D. Gwinn Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 15th 1917 to June 12th 1920 that I last saw h[illegible] alive on June 12th 1920 and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Cardiac Asthma
(Duration) 3 Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) John Booth M. D.
June 14 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jordan Valley Ore. DATE OF BURIAL: June 15 1920
20. UNDERTAKER: Cemetery & Sidewalks ADDRESS: Boise

Dr Booth

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 1004

Stewart
State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30717

Registered No. 226

1. **PLACE OF DEATH**

County of Ada

City of Boise

(No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Bessie E. Swet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Married

6. **DATE OF BIRTH** Sept (Month) 5 (Day) 1896 (Year)

7. **AGE** 23 Yrs. 9 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Missouri

10. **NAME OF FATHER** William J Gosnor

11. **BIRTHPLACE OF FATHER** (State or Country) Mo

12. **MAIDEN NAME OF MOTHER** Jessie B Owens

13. **BIRTHPLACE OF MOTHER** (State or Country) Mo

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Geo E Swet

(Address) Nampa Ida R 4

15. Filed June 17 1920 L. P. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** June (Month) 16 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from June 1 1920 to June 16 1920 that I last saw h..... alive on June 16 1920 and that death occurred on the date stated above, at 11 45 A. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia - Chr

..... (Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) Myocarditis

Oct. 1919

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James L. Stewart M. D.

19..... (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL, OR REMOVAL** Nampa Idaho | **DATE OF BURIAL** June 18 1920

20. **UNDERTAKER** Summers & Krebs | **ADDRESS** Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30718
Registered No. 228

1. PLACE OF DEATH
County of Ada
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. St Alphonsus Hosp St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Louis Grebe.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH: June (Month) 14 (Day) 1920 (Year)

7. AGE: ___ Yrs. ___ Mos. ___ ds.
IF LESS than 1 day how many 13 hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Harry L. Grebe.

11. BIRTHPLACE OF FATHER (State or Country): Nebraska.

12. MAIDEN NAME OF MOTHER: Grace M. Bruey

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry L. Grebe
(Address) Mountain Home Ida

15. Filed June 18 1920 L P Inman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/14 1920 to 6/14 1920
that I last saw h[illegible] alive on 6/14 1920
and that death occurred on the date stated above, at 9:45 M.
The CAUSE OF DEATH* was as follows:
Toxic Convulsions from Albuminuria of Mother.
(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Albuminuria of Mother
(Duration) yrs. 5 mos. ds.
(Signed) Fred A. Fellows M. D.
6/15 1920 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	June 16 1920.
20. UNDERTAKER	**ADDRESS**
Summers & Cobb.	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Collister.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30719

Registered No. 229

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 613 Washington St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William O. Weiss.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Widowed~~ Widower

6. DATE OF BIRTH: Oct 18 (Month) 1834 (Day) (Year)

7. AGE: 85 Yrs. 7 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Russia.

10. NAME OF FATHER: Tobias Weiss

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Weiss

(Address) Emmett Idaho.

15. Filed June 18 1920 L. P. Inman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 17 (Month) (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1920, to June 3 1920, that I last saw h— alive on June 5 1920, and that death occurred on the date stated above, at 5:45 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jo Barnett M. D.

6/17 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: June 19 1920

20. UNDERTAKER: Summers & Cobb. ADDRESS: Boise Ida.

Amended

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

(No. ....., ... St.)

Registration District No. 2

Primary Registration District No. 1004

File No. 30720

Registered No. 2302

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie B Land Ross.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write one word.)
F.	White.	W (Widowed)

6. DATE OF BIRTH: March 11 1860
(Month) (Day) (Year)

7. AGE: 60 Yrs. 11 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Kentucky.

10. NAME OF FATHER: Ila Davis

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Harriet Gilchrist

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Bland Gordon
(Address) .....

15. Filed Jun 18 1920 L P Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 15 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920, to June 15 1920
that I last saw h[illegible] alive on June 14 1920.
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage

(Duration) ..... Yrs. 1 mos. 15 ds.
Contributory (Secondary) Par. nephritis Revised
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W S Lutz M. D.
6-17 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	June 17 1920
20. UNDERTAKER	ADDRESS
Summers & Gebs	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
(No. ..... , ... St.)

File No. 30721
Registered No. 232

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence E. Bunnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 12 (Day) 1880 (Year)

7. AGE: 40 Yrs. 8 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fireman
(b) General nature of industry, business or establishment in which employed (or employer): Boise City Fire Department

9. BIRTHPLACE (State or Country): Dalles Oregon

10. NAME OF FATHER: Chas A Bunnell

11. BIRTHPLACE OF FATHER (State or Country): U. S. A.

12. MAIDEN NAME OF MOTHER: Zoe M. Bunnell

13. BIRTHPLACE OF MOTHER (State or Country): U. York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. A. Bunnell Sr.
(Address) Mt. Home Idaho

15. Filed June 19 1920 L. O. Symms Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1920 to June 18 1920 that I last saw him alive on June 17 1920 and that death occurred on the date stated above, at 2 a. M.
The CAUSE OF DEATH* was as follows:
Cystemic Lues
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A Adams M. D.
June 19 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/21 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 30723
Registered No. 235

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1021 Miller St. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Francis Cooney
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 4 — 1920.
(Month) (Day) (Year)

7. AGE: — Yrs. 1 Mos. 18 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer): None.

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: Harry T. Cooney.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Iris Graham.

13. BIRTHPLACE OF MOTHER (State or Country): Carey, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise Idaho

15. Filed Jun 22 1920 L. O. Graves
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June, 22 — 1920.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1920, to June 22 1920
that I last saw him alive on June 22 1920
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:
Enteritis
(Duration) ... Yrs. ... mos. 14 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) P P French M. D.
6/22 1920 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meiser — Idaho. DATE OF BURIAL: 6/23 19 2

20. UNDERTAKER: W McBratney ADDRESS: Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30124

Registration District No. 2

Primary Registration District No. 1004

Registered No. 237

1. PLACE OF DEATH

County of Ada

City of Boise, (No. 1615 No 25 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susie J Diers.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or the word).

6. DATE OF BIRTH: March 27 (Month) (Day) 1858 (Year)

7. AGE: 62 Yrs. 2 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: James R. Robbins

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania.

12. MAIDEN NAME OF MOTHER: Eliza J. Scott

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J R Diers

(Address) .....

15. Filed 6/26 1920 L C Forman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 25 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw her alive on June 25 1920,

and that death occurred on the date stated above, at 4 p M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary): None.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. Willis Almond M. D.

6/26 1920 (Address) 500 Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mackay Idaho. DATE OF BURIAL: June 28 1920

20. UNDERTAKER: Summers & Kibbe. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30725

Registered No. 238

1. PLACE OF DEATH

County of Ada

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1317 Alturas St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sallie C. Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: June — 1857 (Month) (Day) (Year)

7. AGE: 63 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): South Carolina

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Harry J Cebs.

(Address) Boise Idaho.

15. Filed Jun 29 1930 L. O Lyman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 27 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19— to — 19—

that I last saw her ~~dead~~ alive on June 27 1930

and that death occurred on the date stated above, at about 11 A.M.

The CAUSE OF DEATH* was as follows:

Hanging (Suicide)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry J Cebs. Ada Co Cor

6/28 1930. (Address) Boise Idaho. Deputy Co

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: June 31 1930.

20. UNDERTAKER: Summers & Cebs. — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

City of Boise (No. 410 St.) Registered No. 209

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josie Sullivan Green

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 2 (Day) 1869 (Year)

7. AGE: 51 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Joseph Sullivan

11. BIRTHPLACE OF FATHER (State or Country): Ore.

12. MAIDEN NAME OF MOTHER: Fannie Todd

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Green
(Address) Nyssa Oregon

15. Filed June 29 1920 L O Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1920 to June 29 1920, that I last saw h.. alive on June 25 1920, and that death occurred on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:
Chr Operation - Cholelithiasis
Died from explanation
(Duration) 5 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. K. Pullman M. D.
6 19 (Address) 6/29 - 20 Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho | DATE OF BURIAL: June 30 1920

20. UNDERTAKER: Schreiber & Hidenfeldt | ADDRESS: Boise

Ez Wilson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-25 M. 1-19.

13

Pittinger

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada — Registration District No. 8

City of Boise — Primary Registration District No. 6 — File No. 30727

(No. Soldiers Home Hospital St.) — Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Prossers.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	W (Write the word)

6. DATE OF BIRTH: May (Month) — (Day) — 1845 (Year)

7. AGE: 75 Yrs. — Mos. — ds. IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Civil War Veteran
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. F. Burnett.
(Address) Boise Idaho.

15. Filed June 1 1920 — L. P. Lyman, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/1 1920 to 5/30 1920 that I last saw h[illegible] alive on 5/29 1920 and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:

Tabo-Paresis.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 1 yrs. ..... mos. ..... ds.

6/1 (Signed) H. H. Tatum M. D.
1920 (Address) Owyhee Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	June 1 1920

20. UNDERTAKER: Summers & Webb — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration [illegible] No. 8

County of Ada

Primary Registration District No. 2004

File No. 30728-A

City of Boise,

(No. Soldier's Home St.)

Registered No. 54

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin F. Fisher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Married

6. DATE OF BIRTH

June (Month) 13 (Day) 1842 (Year)

7. AGE

77 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Samuel Fisher

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Betsy Tremper

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. P. Pierce

(Address) 505 Franklin St

15. Filed April 27 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/29 1920 to 6/3/ 1920 that I last saw him alive on 6/2/ 1920, and that death occurred on the date stated above, at 5:30 A. M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred A. Tuttle M. D.

4/25 1921 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	June 4 1920
20. UNDERTAKER	ADDRESS
Summers & Krebs	Boise Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

See Amended Certificate - correct name

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30728

Registered No. 54

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. Soldiers Home St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank T. Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: June (Month) 13 (Day) 1842 (Year)

7. AGE: 77 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Samuel Fisher

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Betsy Tremper

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles P. Pierce

(Address)

15. Filed June 3 1920 L. O. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/29 1920, to 6/3 1920 that I last saw h[illegible] alive on 6/2 1920, and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) Yrs. mos. ds.

Contributory (Secondary) Arterio Sclerosis

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

6/3 1920 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: June 4 1920

20. UNDERTAKER: Summers & Strebs ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30729
Registered No. 65

1. PLACE OF DEATH

County of Ada

City or near Boise

(No. Baldeen Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Linas C. Vaughn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Widower

6. DATE OF BIRTH

1842 (Month) 1 (Day) (Year)

7. AGE

78 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Veteran Civil War

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E. Summers

(Address) Boise Idaho

15. Filed 6/6 1920 L. O. Oman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3/21 1920 to 6/3 1920 that I last saw h alive on 6/1 1920 and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Fred J. Taylor M. D.

6/4 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery DATE OF BURIAL June 7 1920

20. UNDERTAKER Summers & Keck ADDRESS Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30730

Registered No. 56

Registration District No. 8

Primary Registration District No. 2014

1. PLACE OF DEATH

County of Ada

City of near Boise

(No. 1 mile W of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen F. Rich

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Jan (Month) 9 (Day) 1857 (Year)

7. AGE: 63 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: A. J. Walker

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Elizabeth Wilhoite

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J N Walker

(Address) Boise Idaho Route 4

15. Filed Jan 6 1920 L. P. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 24th 1920, to June 5th 1920, that I last saw h[illegible] alive on May 29th 1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes Coma

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Diabetes

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Bauch M. D.

June 7 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Idaho — DATE OF BURIAL: June 7 1920

20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30731

Registered No. 57

1. **PLACE OF DEATH**

County of Ada

City of Boise Valley

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. Ada Co Boise Valley St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** George E. Dahle Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Single (Write the word.)

6. **DATE OF BIRTH** Jan (Month) 16 (Day) 1898 (Year)

7. **AGE** 21 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Cattle business

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Iowa.

10. **NAME OF FATHER** G. E. Dahle

11. **BIRTHPLACE OF FATHER** (State or Country) Iowa.

12. **MAIDEN NAME OF MOTHER** Agnes Iesonen

13. **BIRTHPLACE OF MOTHER** (State or Country) Iowa.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) J. Edgar Dahle

(Address) Boise Idaho

15. Filed Jan 7 1920 L. O. Green Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** May (Month) 29 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Was accidentally to drowned 19....,

that I last saw h.... alive on 19....,

and that death occurred on the date stated above, at 2 P. M.

The **CAUSE OF DEATH*** was as follows:

Accidently drowned

Body recovered Dear Walley Ferry June 5 - 1920

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. Edgar Dahle Brother M. D.

19.... (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Ft Johnsonville | **DATE OF BURIAL** 6/7 1920

20. **UNDERTAKER** Schroeder & Lockhart | **ADDRESS** Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5032

Registered No. 58

1. PLACE OF DEATH

County of Ada

City of Meridian

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2 4 (No. Ada to Meridian St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Asa Endicott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 2 1907 (Month) (Day) (Year)

7. AGE: 13 Yrs. 2 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: John R. Endicott

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Clara C. Blankenship

13. BIRTHPLACE OF MOTHER (State or Country): Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John R Endicott
(Address) Boise Ida

15. Filed June 6 1920 L. P. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That ~~I attended~~ deceased ~~from~~ died accidently by Drowning in Snake River May 29 1920 that I last saw h.... alive on May 28 1920, and ~~that~~ death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Accidently drowned while in Snake River

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John R Endicott M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/6 1920

20. UNDERTAKER: Schreiber & Heidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 30733
Registered No. 54

1. PLACE OF DEATH
County of Ada
City of 9 Miles West
(No. 9 Miles W. of Boise St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Elizabeth De Harty
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 25th (Day) 1846 (Year)

7. AGE: 74 Yrs. — Mos. 10 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Jacob Arbaugh

11. BIRTHPLACE OF FATHER (State or Country): American

12. MAIDEN NAME OF MOTHER: Elizth Lowery

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. DeHorty
(Address) Meridian Ida.

15. Filed June 7 — 1920 L. P. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 — 1920, to June 5 — 1920, that I last saw h.. alive on June 1920, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Medical Examiner M. D.
6-4 1920 (Address) Meridian Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death..... yrs..... mos..... days. In the State..... yrs..... mos..... days
Where was disease contracted if not at place of death?
Former or usual residence Ada County Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 6/8 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
(No. Soldiers Home Hospital)

File No. 30734
Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada
City of Boise

2. FULL NAME Isaac Tipp.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH June 9 (Month) (Day) 1835 (Year)

7. AGE 85 Yrs. — Mos. 5 ds. IF LESS than 1 day how many ... hrs. or ... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Pennsylvania.

10. NAME OF FATHER John Tipp.

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania.

12. MAIDEN NAME OF MOTHER Elizabeth M. Burke

13. BIRTHPLACE OF MOTHER (State or Country) Pennsylvania.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) ...

15. Filed June 14 1920 L. O. Pinnar Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 12 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to June 12 1920, that I last saw h[illegible] alive on June 12 1920 and that death occurred on the date stated above, at 10:40 A.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Cystitis - Seleroris

(Duration) ... yrs. ... mos. ... ds.

(Signed) Fred C. Fellows M. D.

6/14 1920 (Address) Orofino

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	June 14 1920
20. UNDERTAKER	**ADDRESS**
Summers & Kobi.	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Bowers.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30135

Registered No. 61

Registration District No. 8

Primary Registration District No. 2224

1. PLACE OF DEATH

County of Ada

City of So Boise.

(No. So. 1 Bainbridge St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilhelmina Pearson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: June 19 (Month) (Day) 1893 (Year)

7. AGE: 26 Yrs. 11 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Arne Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Anna Jorgensen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Pearson

(Address) Boise Idaho

15. Filed June 18 1920 L. P. Summers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 16 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1 1920, to June 16 1920 that I last saw her alive on 6-16 1920 and that death occurred on the date stated above, at 12 o'P M.

The CAUSE OF DEATH* was as follows:

Intercurrent

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. C. Brown M. D.

6/17 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: June 19 1920

20. UNDERTAKER: Summers & Webb — ADDRESS: Boise Ida

FORM V, S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30736
Registered No. 62

1. PLACE OF DEATH
County of Ada
City of (or Town) Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8
Primary Registration District No. 2014
(No. North 1st Mountain View School St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Delta Genevieve Quigley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 31 (Day) 1920 (Year)

7. AGE: ____ Yrs. 4 Mos. 23 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Idaho

10. NAME OF FATHER: Leonard Quigley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nellie Wilcomme

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Stone
(Address) Boise

15. Filed June 23 1920
L. P. Truman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1920, to June 23 1920 that I last saw h[illegible] alive on June 20 1920, and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Whooping Cough

(Duration) ____ Yrs. ____ mos. 21 ds.
Contributory (Secondary) Pneumonia
(Duration) ____ yrs. ____ mos. 4 ds.

(Signed) T. M. Braxton M. D.
June 23 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence Shipment

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida. | DATE OF BURIAL: 6/23 19

20. UNDERTAKER: Schreiber & Kidwell Undertaking | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30737

Registered No. 63

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2-04

(No. Bench near Boise St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Haines

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June 22 (Month) (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Austin F. Haines.

11. BIRTHPLACE OF FATHER (State or Country): Nebraska.

12. MAIDEN NAME OF MOTHER: Margaret B Condon

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A L Haines

(Address)

15. Filed Jy 23 1920 L. O. Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 22 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1920, to June 22 1920, that I last saw h.sm. alive on June 22 1920, and that death occurred on the date stated above, at 9.50 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) Yrs. mos. 5 min ds.

Contributory (Secondary) Placenta Previa marginalis

(Duration) yrs. 7 mos. ds.

(Signed) F. M. Bradtan M. D.

June 23 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: June 23 1920

20. UNDERTAKER: Summers & Krebs. — ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Pittenger

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 30738
Registered No. 64

1. PLACE OF DEATH
County of Ada
City of Boise
(No. Soldiers Home Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William B Anthony

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower

6. DATE OF BIRTH: Oct 8 (Month) (Day) 1833 (Year)

7. AGE: 86 Yrs. 8 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farm

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: ——— Anthony

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E Anderson
(Address) ———

15. Filed June 25 1920 L. P. Pfirman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 24 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1920 to June 24 1920
that I last saw h. ~~ina~~ alive on June 22 1920
and that death occurred on the date stated above, at 2:20 P. M.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) 6 Yrs. 0 mos. 0 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Roscoe B Ward M. D.
6/25 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: June 26 1920

20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

STAR-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 30739
Registered No. 25

1. PLACE OF DEATH
County of Boise.
City of
(No. 3 miles of Corbarton St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold P. Lake
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 22 (Day) 1918 (Year)

7. AGE: 2 Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Okla

10. NAME OF FATHER: William H Lake

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Maggie M Jetton

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm H. Lake
(Address) Carbarton, Idaho,

15. Filed June 18 1920 L. P. Pinman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19.. to ——— 19..
that I last saw him ~~alive~~ dead on June 17 1920,
and that death occurred on the date stated above, at 8:1 A. M.
The CAUSE OF DEATH* was as follows:
Fracture of skull.
Crushed by rolling log.
Accidental
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Harry Krebs, Ada Co. Coroner M.D.
6/18 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: June 18 1920

20. UNDERTAKER: Summers & Krebs. ADDRESS: Boise Idaho

State of Idaho,)
(ss
County of Ada.)

Harry Krebs being first duly sworn, deposes and says that he now is and at all times hereinafter mentioned was the duly appointed and acting Deputy Coroner in and for Ada County, Idaho.

That on the 17th day of June, 1920, as such Deputy Coroner he made a certificate setting forth the facts regarding the death of a boy Harold P. Lahe, who was accidentally killed in the hills near Cabarton, Idaho.

That in said certificate affiant stated by mistake that the death of said boy occurred on the 17th day of June, 1920, whereas in fact and in truth said death occurred on the 16th day of June, 1920, and one day prior to the date so stated.

That affiant makes this affidavit for the purpose of correcting said error and mistake made wholly through inadver-

Harry Webb

Subscribed and sworn to before me this 7th day of September, 1920.

W. C. Dumbar

Notary Public for the State of Idaho, residing at Boise, Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3074

Registered No.

1. PLACE OF DEATH

County of Adams

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harrison Camp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1838 (Year)

7. AGE: 81 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Jacob Camp

11. BIRTHPLACE OF FATHER (State or Country): ~~N.Y.~~ Penn.

12. MAIDEN NAME OF MOTHER: Lydia Schuyler

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Camp
(Address) Council

15. Filed June 30 1920 W M Brown
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to June 12 1920, that I last saw h.m. alive on June 12 1920, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Heart failure incident to age

(Duration) Yrs. mos. ds.

Contributory (Secondary) Slight Colon Pneumonia

(Duration) yrs. mos. 7 ds.

(Signed) W M Brown M. D.

June 13 1920 (Address) Council

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho — DATE OF BURIAL: June 14 1920

20. UNDERTAKER: Young — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30771
Registered No. 3347

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8W
Primary Registration District No. 2-1/2
(No. 549 West Center St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oscar B. Steely

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: August 22 1862 (Month) (Day) (Year)

7. AGE: 57 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business or establishment in which employed (or employer): M. D.

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Wm. J. Steely

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Sarah Baker

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs O. B. Steely
(Address) 549 W. Center St

15. Filed June 28 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27th 1910, to June 27th 1920, that I last saw him alive on June 27th 1920, and that death occurred on the date stated above, at 10:50 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectaris

(Duration) ..... Yrs. ..... mos. One ds.

Contributory (Secondary) Fibrous myocarditis

(Duration) one yrs. ..... mos. ..... ds.

(Signed) W. A. Wright M. D.

6/27 1920 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 26 yrs. ..... mos. ..... days. In the State 26 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Penn.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: June 30 1920

20. UNDERTAKER: W. L. McHaffie — ADDRESS: Pocatello

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 30742
Registered No. 3346

1. PLACE OF DEATH.
County of Bannock
City of Inkom
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Bryant Bishop Skeen
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 18 1920 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: /
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. S. Skeen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Irene Bishop

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. S. Skeen
(Address) Inkom Idaho

15. Filed 6-26-29 191.... Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1920, to June 25 1920, that I last saw h.im alive on June 24 1920, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Inanition
.....
.....
(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary) /
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Howard M. D.
6/26/1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days.
In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Inkom Idy | DATE OF BURIAL: June 27 1920

20. UNDERTAKER: Schumacher Bros | ADDRESS: Pocatello Idy

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. Simsal Hospital)

File No. 330743
Registered No. 3345

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Currence Wallihan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widow

6. DATE OF BIRTH: July (Month) 2 (Day) 1836 (Year)

7. AGE: 83 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Linis Johnson

11. BIRTHPLACE OF FATHER (State or Country): N.Y State

12. MAIDEN NAME OF MOTHER: Eliza Newell

13. BIRTHPLACE OF MOTHER (State or Country): Connetecut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Grace Ehrlich
(Address) POCATELLO, IDAHO

15. Filed June 25 1920 J P Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1920, to June 24 1920, that I last saw h.er alive on June 24 1920, and that death occurred on the date stated above, at 9.25 P.M.

The CAUSE OF DEATH* was as follows:

Impacted Bowel -

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Strangulated Inguinal hernea

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) J P Young - M. D.

19 ..... (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State 3 yrs. 6 mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Wisconsen

19. PLACE OF BURIAL OR REMOVAL: Belleville Wisconsin — DATE OF BURIAL: June 25 1920

20. UNDERTAKER: H. L. McHAN — ADDRESS: POCATELLO, IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. In Baggage Car. C S L. Paint Shop St.)

File No. 30714
Registered No. 3344

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob Schneider

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Divorced (Write the word.)

6. DATE OF BIRTH: Sept (Month) 8 (Day) 1868 (Year)

7. AGE: 52 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Odessa Russia

10. NAME OF FATHER: Geo Schneider

11. BIRTHPLACE OF FATHER (State or Country): Odessa Russia

12. MAIDEN NAME OF MOTHER: ~

13. BIRTHPLACE OF MOTHER (State or Country): Odessa Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Randolph Schneider
(Address) 817 No Garfield

15. Filed June 25 1920 O B Reed, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 445 P. M.
The CAUSE OF DEATH* was as follows:

Suicide by Hanging

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John A Zuffa M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: 6/25 1920

20. UNDERTAKER: Fred J Walker — ADDRESS: Pocatello Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. Eli
Primary Registration District No. 216
(No. County Farm St.)
File No. 30745
Registered No. 3343

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Seymour Bowee Mechom
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Dec (Month) 14 (Day) 1 (Year)

7. AGE: 56 Yrs. 6 Mos. 6 ds.
IF LESS than 1 day how many ... hr. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Timber man
(b) General nature of industry, business or establishment in which employed (or employer): and rancher

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Joseph Mechom

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Bowee

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S. W. Mechom
(Address) Argyle rooms.

15. Filed June 23 1920 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1920 to June 20 1920 that I last saw h... alive on June 20 1920 and that death occurred on the date stated above, at 4:15 a M.

The CAUSE OF DEATH* was as follows:

Pneumonia
Focal Tuberculosis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) John D Bowee M. D.
June 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 4 mos. ... days. In the State ... yrs. 6 mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Malad Idaho

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: June 23 1920

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 320716
Registered No. 3342

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 430 N. Garfield St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Franklin Carpenter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write word): Single

6. DATE OF BIRTH: May 24 (Month) 1920 (Year)

7. AGE: — Yrs. 2 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: Garnett E. Carpenter

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Gladys Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Garnett Carpenter
(Address): 430 N. Garfield

15. Filed June 18 1920. R. L. Steele
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 18 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1920, to June 18 1920, that I last saw him alive on June 18 1920, and that death occurred on the date stated above, at 7:40 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary): Enlarged Thymus Gland

(Duration) ..... yrs. 2 mos. 24 ds.

(Signed) W. W. Brothers M. D.

19..... (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: June 19 1920

20. UNDERTAKER: W. L. McMahon ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30747
Registered No. 3341

Registration District No. 84
Primary Registration District No. 216

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Mt View Cemetery St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gonahachi Nishimura

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: June (Month) 27 (Day) 1879 (Year)

7. AGE: 40 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Pool Hall manager
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. Y. Kanaka
(Address) U.S. Bon & Co. Pocatello Ida.

15. Filed June 15 1920
O. R. Steel
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:
Suicid with automatic pistal bul 5 P.M. Saturday 12 end monday June 14

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John A Zupper M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 6 mos. ..... days. In the State ..... yrs. 6 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Bingham Utah

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. | DATE OF BURIAL: June 16 1920

20. UNDERTAKER: H. L. McClain | ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

D. O'Connor

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30748
Registered No. 3340

1. PLACE OF DEATH.
County of Bannock
City or Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. 216 N. 2nd Pear St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosa Munoz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April 10th 1920
(Month) (Day) (Year)

7. AGE: yrs. 2 mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: (none)
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George Munoz

11. BIRTHPLACE OF FATHER (State or Country): New Mexico

12. MAIDEN NAME OF MOTHER: Leopoldia Lena

13. BIRTHPLACE OF MOTHER (State or Country): New Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Munoz
(Address) 216 N. 2nd Pocatello

15. Filed June 23 1920 O. K. Heath Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10th 1920 to June 24th 1920
that I last saw h[er] alive on June 24th 1920
and that death occurred on the date stated above, at 2 H. M.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) yrs. mos. 2 ds.
Contributory (Secondary) Pertussis
(Duration) yrs. mos. 7 ds.

(Signed) James F. Connor M. D.
6-24 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Mem'l Park | DATE OF BURIAL: June 24 1920

20. UNDERTAKER: Schumacher & Hay | ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bannock
City of [redacted]
If death occurred outside city or usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 4161
(No. ____, ____ St.)

File No. 34 30749
Registered No. 333

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Grant Bishop Skeen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH: June (Month) 18 (Day) 1920 (Year)

7. AGE: ____ yrs. ____ mos. 4 ds. IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ____
(b) General nature of industry business, or dstablishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. S. Skeen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Irene Bishop

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. S. Skeen
(Address) Inkom Ida

15. Filed June 24 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1920 to June 21 1920 that I last saw h[illegible] alive on June 20 1920 and that death occurred on the date stated above, at 9P M.

The CAUSE OF DEATH* was as follows: Haemorhage of the Newborn

(Duration) ____ yrs. ____ mos. One ds.

Contributory (Secondary): ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) W. F. Howard M. D.
6/22/1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Inkom — DATE OF BURIAL: June 23 1920

20. UNDERTAKER: Schumacher & Hay — ADDRESS: City

SYMS - YORK CO., PTRS. & SDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 84
County of Bannock Primary Registration District No. 2161
City of Pocatello No. St. Anthony Hospital
If death occurs away from usual residence, give facts called for under special information. 2. FULL NAME Felicien J Bonhomme

File No. 340750
Registered No. 3338
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Exact date unknown / 1882 (Month) (Day) (Year)
7. AGE: 38 yrs. mos. ds. If LESS than 1 day old state hrs. or mins.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Man
(b) General nature of industry business, or dstablishment in which employed (or employer)
9. BIRTHPLACE (State or Country): France
10. NAME OF FATHER: Jean Bonhomme
11. BIRTHPLACE OF FATHER (State or Country): France
12. MAIDEN NAME OF MOTHER: Caroline Jaclard
13. BIRTHPLACE OF MOTHER (State or Country): France
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pierre Bonhomme
(Address) Livingston Mont
15. Filed June 24 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 20 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 20 1920 to June 20 1920 that I last saw h- alive on June 20 1920 and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH was as follows:
Embolism.
Ruptured Blood Vessel
due to High Blood pressure
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) [illegible] M. D.
June 24 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: June 24 1920
20. UNDERTAKER: [illegible] — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30751
Registered No. 3331

Registration District No. 84
Primary Registration District No. 2161

1. PLACE OF DEATH.
County of Bannock
City of Lava Hot Springs (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Graiff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Mar (Month) 13 (Day) 19[illegible] (Year)

7. AGE: ..... Yrs. 15 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho -

10. NAME OF FATHER: Jim Graiff

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Emilie Petschenider

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jim Graiff
(Address) Lava Hot Springs Ida

15. Filed June 20 [illegible] 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18, 1920, to June 18 1920, that I last saw h[illegible] alive on June 18 1920, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning - Child accidentally fell in a ditch of water and partially filled and drowned was discovered and resuscitated efforts
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
19..... (Address) Lava Hot Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lava Hot Springs, Ida
DATE OF BURIAL: June 20 1920

20. UNDERTAKER: [illegible]
ADDRESS: [illegible]

SYMS - YORK CO., PRINTERS, DENVER. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 30752
Registered No. 3336

1. PLACE OF DEATH.
County of Bannock
City of Inkom (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Leroy Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Boy	White	

6. DATE OF BIRTH: March 1st 1920 (Month) (Day) (Year)

7. AGE: ..... yrs. 3 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Inkom. Bannock Co. Idaho

10. NAME OF FATHER: Edgar David Wilson

11. BIRTHPLACE OF FATHER (State or Country): Clyde Cloud Co Kans

12. MAIDEN NAME OF MOTHER: Editha Pearl

13. BIRTHPLACE OF MOTHER (State or Country): Stockton. Rooks Co Kans

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E. D. Wilson
(Address): Inkom. Ida.

15. Filed June 16 1920 O. R. Steel, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 11th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3, 1920 to June 11 1920
that I last saw h... alive on June 11 1920
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Lobular Pneumonia
Purulent Basal Cerebral Spinal Meningitis (Simple)
..... (Duration) ..... yrs. ..... mos. 8 ds.

Contributory — (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. F. Miller M. D.
6-11 1920 (Address) Lava Bell

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Inkom Idy — DATE OF BURIAL: June 11 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

File No. 30753
Registered No. 3335

1. PLACE OF DEATH.

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant (Meese)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb 9th 1920 (Month) (Day) (Year)

7. AGE: 0 Yrs. 3 Mos. 27 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)... Baby in arms.

9. BIRTHPLACE (State or Country): Inkom Idaho

10. NAME OF FATHER: John H. Meese

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Edna Louise Hoagrove

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Father - John Meese
(Address) Inkom Idaho

15. Filed June 24 1920 O P Steele Local Registrar

SYMS-YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 6th 1920 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to June 6 1920, that I last saw h[illegible] alive on June 6 1920, and that death occured on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Mals Nutrition from Birth —
(Duration) ..... Yrs. 3 mos. 29 ds.
Contributory (Secondary) Lobular Pneumonia
(Duration ..... yrs. ..... mos. 7 ds.
(Signed) J. F. Miller (?) M. D.
6-8 1920 (Address) Box 174 Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Inkom Idaho — DATE OF BURIAL: June 8 1920

20. UNDERTAKER: Schumacher & Reed — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 6-15 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Jerrock
City of Tyhee
(No. Tyhee St.)
If death occurred away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
File No. 30754
Registered No. 3334

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. J. D. Ryan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 3 (Day) 1857 (Year)

7. AGE: 63 Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Woodstock Canada

10. NAME OF FATHER: - Haslam

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: - Bartley

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Ryan
(Address) Tyhee

15. Filed June 11 1920 O. B. Dixon Local Registrar

SYMS-YORK CO., PRINTERS & STATIONERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1920 to June 10 1920
that I last saw h[illegible] alive on June 10 1920
and that death occurred on the date stated above, at 2.40 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Malnutrition
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Lyon M. D.
6/10 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thayer Mo | DATE OF BURIAL: 11/6 1920

20. UNDERTAKER: T. T. Walker ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. For instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

30755

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 3 X 4
Registered No. 3333

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. St. Anthony Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Ellis Pitchey

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: August 27 1919 (Month) (Day) (Year)

7. AGE: — yrs. 9 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: C Frank Pitchey

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Lalla Martin

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C Frank Pitchey
(Address) 618 - No Main

15. Filed June 11 1920 O R Steed Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1920, to June 9 1920, that I last saw h— alive on June 9 1920, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Otitis Media

(Duration) yrs. mos. 10 ds.
Contributory (Secondary) Cerebral Meningitis
(Duration) yrs. mos. 3 ds.

(Signed) J H Sprague M. D.
6-10 1920 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem | DATE OF BURIAL: June 11 1920

20. UNDERTAKER: Schumacher & Hall | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

30756

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3 X 4

Registered No. 3332

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. 833 E Wyeth St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Mary Bedot

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Nov 30 1919 (Month) (Day) (Year)

7. AGE: ..... yrs. 7 mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Raymond Bedot

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Helen Espie

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Raymond Bedot

(Address) Pocatello Ida

15. Filed June 8 1920 J. B. Steely Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 8th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5, 1920, to June 7 1920

that I last saw her alive on June 7 1920

and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. B. Steely M. D.

June 8 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ingram View — DATE OF BURIAL: June 9th 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30757 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 54
Primary Registration District No. 2161
(No. Lynn Bros Hos St.)
File No. 3 X 4
Registered No. 3331
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME June Francis Plant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: May 23 1892 (Month) (Day) (Year)

7. AGE: 28 Yrs. — Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James Rohde

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Stine Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William C. Plant
(Address) 331 So. arthur St

15. Filed June 7 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May June 5 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1920, to June 5th 1920 that I last saw her alive on June 5th 1920, and that death occurred on the date stated above, at 8 P. M.,
The CAUSE OF DEATH* was as follows:
Paralysis of bowels

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Operation
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. W. Lynn M. D.
June 7 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. In the State 12 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Utah

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: June 8 1920

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30758 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2961
File No. 334
Registered No. 3330

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 1135 East Bonton St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm M. Thomas Turman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: January (Month) 6th (Day) 1852 (Year)

7. AGE: 68 Yrs. 4 Mos. 24 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Thomas D Turman

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Margaret Drummond

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo E Turman
(Address) 1135 East Benton

15. Filed June 2 1920 O P Lloyd Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920 to June 1st 1920 that I last saw h[illegible] alive on June 1st 1920, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic parenchymatous Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Asthma

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.

6/3 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery DATE OF BURIAL: 6/4 1920

UNDERTAKER: W H Naeve ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30759 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 374
Registered No. 3327

1. PLACE OF DEATH.
County of Bannock
City of Bancroft
(No. 1/2 mile East of Bancroft St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Jennings

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Unknown (Month) 1 (Day) (Year)

7. AGE
Unknown yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Coroner of Bannock County
(Address) Pocatello Ida

15. Filed June 2, 1920 O B Greer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 28 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....191..., to ....191...,
that I last saw h....alive on....191...,
and that death occurred on the date stated above, at....M.
The CAUSE OF DEATH* was as follows:

Murder By gunshot wound

(Duration) ....yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) 1 yrs. mos. ds.

(Signed) S. B. Ingman Coroner
6-2-1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Los Angeles Calif. DATE OF BURIAL: June 12 1920

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30766

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 3 X 4
Registered No. 3328

1. PLACE OF DEATH.
County of Bannock
City of Bancroft (No. 1½ miles East of Bancroft)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank D Jennings

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Unknown 1
(Month) (Day) (Year)

7. AGE
Unknown yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Salesman
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Coroner of Bannock County, Pocatello Ida
(Address)

15. Filed June 2 1920 O B Stacy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
May 28 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Murder by gunshot wounds

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S S Ferguson Coroner M. D.
5-6 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Los Angeles Calif	June 12 1920
20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30761

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 32
Registered No. 3327

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. St Anthonys Hosp)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maytha Myrtle York
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Feb (Month) 17 (Day) 1901 (Year)

7. AGE: 19 Yrs. 3 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Allen Pyle.

11. BIRTHPLACE OF FATHER (State or Country): Tennesee

12. MAIDEN NAME OF MOTHER: Victora Spock

13. BIRTHPLACE OF MOTHER (State or Country): Tennesee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry L. York
(Address) 1705 Wilson ave

15. Filed May 26 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1920 to May 25 1920, that I last saw her alive on May 25 1920, and that death occurred on the date stated above, at 1000 P.M.

The CAUSE OF DEATH* was as follows:

Encephalitis Lathargica

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Parks M. D.
May 26 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. 9 days. In the State 2 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Tennessee

19. PLACE OF BURIAL OR REMOVAL: Pall Mall Tennesee
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: H. L. McHan
ADDRESS: Pocatello Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30762

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 33
Registered No. 3326

1. PLACE OF DEATH
County of Bannock.
City of Pocatello.
(No. 225 N. Lincoln St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cora Hazel Haines
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb 26 1920 (Month) (Day) (Year)

7. AGE: — Yrs. 3 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bannock.

10. NAME OF FATHER: Brainard M. Haines.

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Helen Werner

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Brainard M. Haines
(Address) 225 N. Lincoln

15. Filed May 26 1920 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 25 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to May 25 1920, that I last saw her alive on May 25 1920, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth. -

Bronchiectasis.

(Duration) ... Yrs. ... mos. 10 ds.

Contributory (Secondary)

(Duration) ... Yrs. ... mos. ... ds.

(Signed) L D Kay M. D.

5-26 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 3 mos. ... days. In the State ... yrs. 3 mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence Pocatello Idaho.

19. PLACE OF BURIAL OR REMOVAL: Mt. View Cemetery — DATE OF BURIAL: May 26 1920

20. UNDERTAKER: H. L. McFarr — ADDRESS: 215 So Main

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30763

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 33
Registered No. 3324

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice L. Melton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct 10 1886 (Month) (Day) (Year)

7. AGE: 38 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Thomas Lemon

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary Grover

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. A. Melton
(Address) Arco, Idaho

15. Filed May 20 1920 B. Steed Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 7 1920 to May 20 1920 that I last saw h[illegible] alive on May 20 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows: Nephritis -

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. H. Rees M. D.

May 21 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 14 days. In the State 2 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Arco, Idaho

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho | DATE OF BURIAL: May 21 1920

20. UNDERTAKER: H. L. McClanahan | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30764

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 33
Registered No. 3325

1. PLACE OF DEATH
County of Bannock
City of POCATELLO, IDAHO
(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William D. Woodard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male.	white	Widower

6. DATE OF BIRTH
Jan 16 1846
(Month) (Day) (Year)

7. AGE
74 Yrs. 4 Mos. 22 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Wisconsin

10. NAME OF FATHER W. D. Woodard

11. BIRTHPLACE OF FATHER
(State or Country) U. S. A.

12. MAIDEN NAME OF MOTHER Achsah Nelson

13. BIRTHPLACE OF MOTHER
(State or Country) U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dell W. Woodard
(Address) Pocatello, Idaho.

15.
Filed May 23 1924
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May 23 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1920 to May 23 1920
that I last saw him alive on May 23 1920,
and that death occurred on the date stated above, at 8 1920 M.
The CAUSE OF DEATH* was as follows:

Gangrene of gendalia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) L. L. Ray M. D.
5-23 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 3 days. In the State 3 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Canada.

19. PLACE OF BURIAL OR REMOVAL Rexburg Idaho — DATE OF BURIAL May 25 1920

20. UNDERTAKER H. L. McHAN — ADDRESS POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

30765

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bear Lake
City of Paris
Registration District No. 33
Primary Registration District No. 2132
(No. ....., ... St.)
File No. 110
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Delbert Scheidegger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb (Month) 2 (Day) 1920 (Year)

7. AGE: ....Yrs. 5 Mos. 3 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: John Wm Scheidegger

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Martha Ochsenbein

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J. W. Scheidegger
(Address) Paris Idaho.

15. Filed 7/10 1920 R. J. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1920 to July 5 1920 that I last saw h[illegible]alive on July 5 1920 and that death occured on the date stated above, at 6.25 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar, L L L and R. L. Pneumonia

.....(Duration) .....Yrs. .....mos. 7 ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) C. O. Magee M. D.
7/5 1920 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paris
DATE OF BURIAL: 7/10 1920

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-19.

30766

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bear Lake. Registration District No. 33

City of Lanark. Primary Registration District No. 2133

(No. ..... St.)

File No. 111

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grover Burns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	W.	Single

6. DATE OF BIRTH: June (Month) 1 (Day) 1920 (Year)

7. AGE: ..... Yrs. Mos. 3 days. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: baby.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lanark.

10. NAME OF FATHER: John Burns

11. BIRTHPLACE OF FATHER (State or Country): Paris Idaho.

12. MAIDEN NAME OF MOTHER: Mabel H. Bateman

13. BIRTHPLACE OF MOTHER (State or Country): Bloomington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johnie V. Burns
(Address) .....

15. Filed 7/7/20 19..... V. J. Sutton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Med 19 not attend 19, that I last saw h alive on 19, and that death occurred on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows:
Cold. With bad cough
Possibly Whooping cough?

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Johnie V. Burns Jr. M.D.
7/7/1920 (Address) Lanark Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lanark I.

DATE OF BURIAL: 7/8/1920

20. UNDERTAKER: Bishop Casey

ADDRESS: Lanark.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No.
File No. 1 30767
Registered No. 15

1. PLACE OF DEATH
County of Benewah
City of Or Saint Ida (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sol Louis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 75 about Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Coeur de Alene Reservation

10. NAME OF FATHER: — Not Known

11. BIRTHPLACE OF FATHER (State or Country): Coeur d Alene Reservation

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Joe Seltice
(Address):

15. Filed June 8 1920 — J. L. Bihan, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1920 to June 2 1920 that I last saw him alive on June 2 1920, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Nelson M. D.

..... 19 ..... (Address) Tensed Ida

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal** or **Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hemet, Idaho — DATE OF BURIAL: June 5 1920

20. UNDERTAKER: J. Folcom — ADDRESS: Hemet

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1 30769

Registered No. 16

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Benewah

City of Hemet

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 31

Primary Registration District No.

(No. ..... St.)

2. FULL NAME Tuyan Charles

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. (Month) ..... (Day) ..... 1903 (Year)

7. AGE: 17 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hemet Ida

10. NAME OF FATHER: Tuyan Charles

11. BIRTHPLACE OF FATHER (State or Country): Spokane Reserv.

12. MAIDEN NAME OF MOTHER: Ann Mary

13. BIRTHPLACE OF MOTHER (State or Country): Hemet Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jos Sherman

(Address) Hemet Ida

15. Filed June 21 1920 — J. Le Bihan, Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) June (Day) 23 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Consumption

No physician attended

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hemet Ida — DATE OF BURIAL: June 26 1920

20. UNDERTAKER: J. Falcon — ADDRESS: Hemet

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30770

Registered No. 28

1. PLACE OF DEATH.

County of Benewah

City of St. Maries

Registration District No. 32

Primary Registration District No. 2049

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Milbrandt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct. (Month) 1 (Day) 1861 (Year)

7. AGE: 58 Yrs. 8 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Fred Milbrandt

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Louse Meijer

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) August L Milbrandt

(Address) Tensum N-D

15. Filed June 29 1920 H E Lumph Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1920, to June 27 1920, that I last saw h. alive on June 27 1920, and that death occured on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:

Accidental injuries consisting of Basal skull fracture - ruptured Kidney - fract ribs - punctured lung

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Deboyette M. D.

6/28 1920 (Address) St. Maries

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 6/30 1920

20. UNDERTAKER: H Edmt Co. — ADDRESS: St M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE-YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 30771
Registered No. 27

1. PLACE OF DEATH.
County of Bingham
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W W Clelland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Jan. (Month) 14 (Day) 1875 (Year)
7. AGE: 45 Yrs. 5 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: R.R. Conductor
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: H. P. Clelland
11. BIRTHPLACE OF FATHER (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Mary J. Patterson
13. BIRTHPLACE OF MOTHER (State or Country): Ohio
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mildred Clelland
(Address) San Francisco Cal
15. Filed June 23 1920 — H E Smith — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from X 191..., to X 191..., that I last saw h... alive on X 191..., and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Accidentely falling under a train, Cold pressing over Body causing instant death
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration ... yrs. ... mos. ... ds.
(Signed) Geo. L. Mitchell Probate ~~M. D.~~
423 1920 (Address) Used St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 6/25 1920
20. UNDERTAKER: H E Lemp Co. — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 30773
Registered No. 25

1. PLACE OF DEATH.
County of Benewah
City of St. Maries
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Abbott

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
March (Month) 12 (Day) 1844 (Year)

7. AGE
75 Yrs. 6 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Hancock Co Ill

10. NAME OF FATHER
Benjamin Abbott

11. BIRTHPLACE OF FATHER
(State or Country) Kentucky

12. MAIDEN NAME OF MOTHER
Francis Dale

13. BIRTHPLACE OF MOTHER
(State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Morrison Abbott
(Address) Plummer Idaho

15.
Filed June 24 1920
H E Hyatt
Local Registrar

SYMS-YORK CO., PTRS. & RDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1920, to June 19 1920, that I last saw him alive on June 18 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemmorhage

(Duration) Yrs. 4 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) O D Platt M. D.

6/20 1920 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 6/24 1920

20. UNDERTAKER: Mitchell & Meagher — ADDRESS: St Maries Ida

FORM . S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)

File No. 30774
Registered No. X4

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Mullan Creek
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nels Herbert Nelson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. May (Month) 19 (Day) 1894 (Year)

7. AGE: 26 Yrs. ..... Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... lumberman
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Ekman
(Address) Spokane Wn.

15. Filed June 21 1920 H E Hunt Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1920 to ..... 191....,
that I last saw h.....alive on ..... 191....,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Lacerations and fractured Skull - bruises about body. Caused by drift Water & Logs.
(Duration) Instantly Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Alcorn { Coroner / Bureau. C. } M. D.
June 17 1920 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: June 21 1920

20. UNDERTAKER: Mitchell & Mraz — ADDRESS: St. Maries.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30775

Registration District No. 32
Primary Registration District No. 2049
(No. ....., ... St.)
Registered No. 23

1. PLACE OF DEATH.
County of Bonneville
City of St. Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hurst Cochrane

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Dec. (Month) 24 (Day) 1919 (Year)

7. AGE ..... Yrs. 5 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER C. R. Cochrane

11. BIRTHPLACE OF FATHER (State or Country) Wis.

12. MAIDEN NAME OF MOTHER Lilla E. Lewis

13. BIRTHPLACE OF MOTHER (State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. R. Cochrane
(Address) St. Maries Ida

15. Filed June 16 1920 H. E. Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1920, to June 16 1920, that I last saw him alive on June 16th 1920, and that death occured on the date stated above, at 6.45 A.M.

The CAUSE OF DEATH* was as follows:
Sarcoma of Left Kidney
Probably Devil's Club
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas D Platt M. D.
June 1920 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery, St. Maries	June 17 1920

20. UNDERTAKER	ADDRESS
Hetherington Co	St. Maries Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 30776
Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Benewah
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adriana Callahan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 8 (Day) 1868 (Year)

7. AGE: 51 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Geo F. Callahan

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Sophie B. Holmes

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. F. Meacham
(Address) Benewah Wash.

15. Filed June 16 1920 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:
Brain Hemorage caused by a Blow on head by a Revolver in hands of R.V. Irvine
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H. L. Alcorn coroner M. D.
6/16 1920 (Address) St Maries Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roseburg Oregon — DATE OF BURIAL: 6-21-1920

20. UNDERTAKER: H E Hunt Co. — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 30777
Registered No. 21

1. PLACE OF DEATH.
County of Benewah
City of St. Maries (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adell Henrietta Vogle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. August 15 (Month) (Day) 1918 (Year)

7. AGE: 1 Yrs. 10 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Benewah Co. Idaho

10. NAME OF FATHER Henry Vogle

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Anna Wolfe

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Henry Vogle
(Address) St. Maries

15. Filed June 15 1920 H E Hunt Local Registrar

SYMS-YORK CO., PTRS. & STNRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1920, to June 13 1920, that I last saw h alive on June 13 1920, and that death occured on the date stated above, at 12 30 P.M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Eczema from birth
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Drs. J. E. Monahan D.C. M.D.
June 15 1920 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St. Maries Idaho — DATE OF BURIAL: June 15 1920

20. UNDERTAKER: Mitchell & Merage — ADDRESS: St Maries,

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30778
Registered No. 19

Registration District No. 46
Primary Registration District No. 2123
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Benewah
City of Plummer

2. FULL NAME Theodore James Olmstead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec (Month) 23 (Day) 18 (Year)

7. AGE: 56 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Dealer
(b) General nature of industry, business, or establishment in which employed (or employer): Saw mill owner

9. BIRTHPLACE (State or Country): Madison, Wisc

10. NAME OF FATHER: J. J. Olmstead

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Susan Alexander

13. BIRTHPLACE OF MOTHER (State or Country): Madison Wisc

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. T. J. Olmstead
(Address) Plummer, Ida.

15. Filed June 15 1920. [signature] Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1920 to June 1 1920
that I last saw h.im alive on June 1 1920
and that death occurred on the date stated above, at 5 30 P. M.

The CAUSE OF DEATH* was as follows: Burns, Scalded with steam
Immediate cause Burns
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) J. A. Nelson M. D.
June 2 1920. (Address) Tekoa Wn

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane (Greenwood) — DATE OF BURIAL: 6/7 1920

20. UNDERTAKER: Bozeman & Jaeger — ADDRESS: Spokane

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 30779
Registered No. 73

1. PLACE OF DEATH
County of Bingham
City of Moreland
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Calvin Wheeler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: August 7 1840 (Month) (Day) (Year)

7. AGE: 79 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine (U S)

10. NAME OF FATHER: Levi W. Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Mary Ann Arnold

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): David Wheeler
(Address): Blackfoot R D 8

15. Filed June 7 1920 Mrs Nalen E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 5 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920 to June 5 1920
that I last saw him alive on June 3 1920
and that death occurred on the date stated above, at 5:55 P.M.

The CAUSE OF DEATH* was as follows:

Diffuse Uremia, Nephritis

(Duration) — Yrs. 1 mos. — ds.

Contributory (Secondary): Enlarged Prostate

(Duration) 5 yrs. — mos. — ds.

(Signed) A W Beck M. D.

6/5 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Cemetery — DATE OF BURIAL: June 7 1920

20. UNDERTAKER: Ed L Egli — ADDRESS: Blackfoot

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 30780
Registered No. 73

1. PLACE OF DEATH

County of Bingham
City of Thomas
(No. RFD 2 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ross Daniel Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 29 1920 (Month) (Day) (Year)

7. AGE: ....Yrs. ....Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Thomas Idaho

10. NAME OF FATHER: J D Williams

11. BIRTHPLACE OF FATHER (State or Country): Ogden Utah

12. MAIDEN NAME OF MOTHER: Althea M Hovick

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J D Williams
(Address) Blackfoot RD #2 Box 128

15. Filed June 5 19 20 Mrs. E. E. Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 5th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1920 to June 5th 1920
that I last saw h.~~im~~ alive on June 5th 1920
and that death occurred on the date stated above, at 1/4 P M.
The CAUSE OF DEATH* was as follows:
Streptococcic Infection
Throat
(Duration) .... Yrs. .... mos. 2 ds.
Contributory (Secondary)
(Duration) .... yrs. .... mos. .... ds.
(Signed) J O Hamptons M. D.
6/5 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .... yrs. .... mos. .... days. In the State .... yrs. .... mos. .... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Cemetery — DATE OF BURIAL .... 19....

20. UNDERTAKER: J H Williams Aclin Undertaker — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot

Registration District No. 121
Primary Registration District No. 2194
(No. Idaho Insane Asylum St.)

File No. 30781
Registered No. 74

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Joseph Harrison Grouse

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: June 8 (Month) (Day) 1920 (Year)

7. AGE: 44 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Upholsterer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Records Institution
(Address) Blackfoot Ida

15. Filed June 8 1920 Mrs N. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 8 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 4 1919, to June 8 1920
that I last saw h alive on June 7 1920
and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:
Exhaustion & Inanition

(Duration) yrs. 2 mos. ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration) yrs. 2 mos. 4 ds.

(Signed) C. A. Toone M. D.
6/9 1920 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 2 mos. 4 ds.
In the insane asylum. State unknown yrs. mos. ds.
Where was disease contracted, if not at place of death? Great Falls
Former or usual residence. Sedalia Missouri

19. PLACE OF BURIAL OR REMOVAL: Gem City Cemetery
DATE OF BURIAL: 6-9 1920

20. UNDERTAKER: E. J. Funk
ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 30782
Registered No. 70

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. Idaho Insane Asylum St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Ralph Pulliam

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: 1897
(Month) (Day) (Year)

7. AGE: 23 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ada Co. Ida.

10. NAME OF FATHER: Ernest Pulliam

11. BIRTHPLACE OF FATHER (State or Country): Missouri Not Known

12. MAIDEN NAME OF MOTHER: Daisy Neff Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Institution's records C. A. Bower M. D. Supt.
(Address) Blackfoot Ida

15. Filed 6-10 1920. Mrs N. E. Patrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 9 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1920, to June 9 1920, that I last saw him alive on 11 A.M June 9 1920 and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:
Status Epilepticus

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Epilepsy
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Bower M. D.
6-10 1920 (Address) Blackfoot

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 3 ds. In the Insane Asylum State 23 yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Blair Idaho
DATE OF BURIAL: 6-10 1920

20. UNDERTAKER: E. J. Peck
ADDRESS: Blackfoot

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1907
File No. 30783
Registered No. 76

1. PLACE OF DEATH

County of Bingham
City of Blackfoot (No. 306 West Judicial St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jessie Cowan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH May 27 1842
(Month) (Day) (Year)

7. AGE 78 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work retired
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Scotland

10. NAME OF FATHER John Cowan

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Jessie Cochran

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Dacre
(Address) Blackfoot Idaho

15. Filed June 16 1920 Mrs. N. E. Pabrie
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1920 to June 13 1920 that I last saw h[illegible] alive on June 13 1920 and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Brights disease

(Duration) 1 Yrs. ~ mos. ~ ds.

Contributory (Secondary)

(Duration) ~ yrs. ~ mos. ~ ds.

(Signed) F. C. Mitchell M. D.

6/14 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Firth City Cemetery	6-16 1920
20. UNDERTAKER	**ADDRESS**
E. O. Peck	Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... , ... St.)

File No. 30784
Registered No. 77

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bingham
City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John O. Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: Sept (Month) 23 (Day) 1854 (Year)

7. AGE: 65 Yrs. 8 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Ollie E Johnson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Adeline Olson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar E Johnson
(Address) Blackfoot #4

15. Filed June 21 1920 N. E. Patrick Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1920 to Apr 15 1920 that I last saw h[illegible] alive on Apr 15 1920 and that death occurred on the date stated above, at 8[illegible]5 M.

The CAUSE OF DEATH* was as follows: Valvular Disease Heart Mitral

(Duration) 10 Yrs. mos. ds.
Contributory (Secondary) Rheu. & Chronic ulcer left leg
(Duration) 15 yrs. mos. ds.

(Signed) N. E. Patrick M. D.
6/21 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland — DATE OF BURIAL: June 22 1920

20. UNDERTAKER: Ed L Egli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine.
City of Obsidian.
(No. ....., ... St.)

Registration District No. 21
Primary Registration District No. 2022
File No. 30785
Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cordelia A. Lansing

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Feb. 7th 1855
(Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R T Miller
(Address) Bellevue Ida.

15.
Filed 6-30 1920 R. F. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 24th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
No Physician

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Hailey, Ida — DATE OF BURIAL: 5-27 1920

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 21

Primary Registration District No. 2022

File No. 30786

County of Blaine

City of Ketchum (No. ....., ... St.)

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Theodore Stage

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: about (Month) 1 (Day) 1854 (Year)

7. AGE: 66 yrs. about mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Henry Lynch
(Address) Clinton Ill.

15.
Filed 6-30 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191..., to — 191...,
that I last saw h— alive on — 191...,
and that death occurred on the date stated above, at a M.

The CAUSE OF DEATH* was as follows:
Cardiac Aneurism

..... (Duration) — yrs. mos. ds.

Contributory (Secondary) —

..... (Duration) yrs. mos. ds.

(Signed) R. H. Wright M. D.

May 19 1920 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ketchum | DATE OF BURIAL: 6-25 1920

20. UNDERTAKER: R. Harris | ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine.
City of Hailey.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 21
Primary Registration District No. 2022
(No. ....., ... St.)

File No. 30787
Registered No. 30
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward D. Browne.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White.	Married.

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
74 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) x W J Barratt
(Address) E. 1023 Augusta Ave. Spokane, Wash.

15. Filed 6-30 1920 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June. 9th 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 191.., to — 191..,
that I last saw h— alive on ..... 191..,
and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Heart trouble
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Robert Kellogham M. D.
6-10 1920 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: — 191..

20. UNDERTAKER: T. D. Harris. ADDRESS: Hailey

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 2155
File No. 30788
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
(No. Sandpoint St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Boyd Dimblin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct 24, Unknown (Month) (Day) 1897 (Year)

7. AGE: 23 Yrs. Mos. ds.
IF LESS than 1 day, how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): in Woods

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Edward Dimblin

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Phoebe Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isaac Dimblin
(Address) Sandpoint, Ida.

15. Filed July 8 1920 FLOYD G. WENDLE Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1920, to June 12 1920, that I last saw he alive on June 11 1920, and that death occurred on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
Intestinal Tuberculosis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. P. Strasheim M. D.
June 17 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint
DATE OF BURIAL: June 14 1920

20. UNDERTAKER: B. H. Pugh
ADDRESS: Sandpoint Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 30789
Registered No.

1. PLACE OF DEATH

County of Bonner
City of
If death occurs away from usual residence, give facts called for under special information.

(No. Humbird L. Co. Camp No. 8. St.)
(Near) Samuels, Idaho.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hansen.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Unknown

6. DATE OF BIRTH: Unknown. (Month) (Day) 1 (Year)

7. AGE: (About 50.) Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Logger in Woods.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Weisenberger
(Address) Samuels, Ida. % Humbird L. Co. (Camp No. 8.)

15. Filed July 8 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) I3 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated the case to 19
that I last saw h alive on 19,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Accidental, and instantaneous.
Accident occured on Pack River in breaking down pile of Logs. Three logs passig over body breaking both legs, and crushing Occipital, Frontal and Temporal bones of head. Thoracic region badly crushed.
Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) Wm Kaemmle M. D.
June 17 1920. (Address) Troy

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence: Unknown

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint, Ida.	June I8 1920.
20. UNDERTAKER	ADDRESS
B.W.Pugh	Sandpoint

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79
Primary Registration District No. 2153
File No. 30790
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint, Ida.
(No. Spruce & Ella. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Grace Wilson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: April, 30, 1873 (Month) (Day) (Year)

7. AGE: 47 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Wm Hartley.

11. BIRTHPLACE OF FATHER (State or Country): Penna.

12. MAIDEN NAME OF MOTHER: Jane Alford.

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Wilson

(Address) Sandpoint, Ida.

15. Filed July 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June, 24, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw her alive on ~~now~~ ..... 19.....,
and that death occurred on the date stated above, at 11 A. M.
The CAUSE OF DEATH* ~~was~~ as follows:

Congestion Pneumonia

(Post influenza)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. G. Anderson M. D.

6/24/1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Walla Walla, Wash. DATE OF BURIAL: June, 27, 1920

20. UNDERTAKER: B. W. Pugh. ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30791

Registered No.

Registration District No. 78

Primary Registration District No. 2155

1. PLACE OF DEATH

County of Booner

City of Edgemere. Ida.

(If outside limits of city or village give township)

If death occurs away from usual residence, give facts called for under special information.

(St.) Edgemere, Ida.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Esther McHenery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Mar, 29, 1880 (Month) (Day) (Year)

7. AGE: 40 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): S. Dak.

10. NAME OF FATHER: M.B.Paddock.

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Ellen Phoenix.

13. BIRTHPLACE OF MOTHER (State or Country): Maine.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Edgemere, Ida.

15. Filed July 8 1920

FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 to 19 that I last saw h[illegible] alive on 19 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Did not see this case until after death.

Carcinoma of left breast

(Duration) 2 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Floyd Wendle M.D. Registrar

(Signed) B.N.Burt Deputy Coroner M. D.

June, 20, 1920. (Address) Sandpoint. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: POST FALLS, IDA.

DATE OF BURIAL: JUNE21 1920.

20. UNDERTAKER: O.W.Stone.

ADDRESS: Rathdrum, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of c

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30792

Registered No.

Registration District No. 78

Primary Registration District No. 2157

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

(No. 433 Pine St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank J. McBride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Jan (Month) 14 (Day) 1867 (Year)

7. AGE: 53 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Real Estate

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Laurence McBride

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Marguritte Hamilton

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James J. McBride

(Address) Sandpoint, Ida.

15. Filed 6-21 1920 Floyd Edwards Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day), 1920 (Year).

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Arrived a few 19 moments 10 after death

~~that I last saw h... alive on ... 19 ...~~

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Aneurism

(Duration) P Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Floyd Edwards M. D.

6-21 1920 (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: June 14, 1920.

20. UNDERTAKER: B. F. Cough ADDRESS: Sandpoint Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30793
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
Registration District No. 79
Primary Registration District No. 2153
(No. City Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Keith Carter.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 31 (Day) 1917 (Year)

7. AGE: 3 Yrs. 11 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Fred F. Carter.

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Della Thomas.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred F. Carter.
(Address) Sandpoint. Ida.

15. Filed July 8 1920
FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30 (Day) 20. 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1920, to June 30 1920, that I last saw him alive on June 30 1920, and that death occurred on the date stated above, at 1:15 P. M.

The CAUSE OF DEATH* was as follows:

Shock. Following amputation of both legs by railroad train at Noxon Montana.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. F. Payne M. D.

July 19 20. (Address) Sandpoint. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: SANDPOINT, IDA. DATE OF BURIAL: JULY 2 1920

20. UNDERTAKER: B.W.PUGH. ADDRESS: SANDPOINT. IDA.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5 78
Primary Registration District No. 2 1 5 5
File No. 30794
Registered No.

1. PLACE OF DEATH
County of Bannock
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma A. Rooks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: June (Month) 21. (Day) 1920 (Year)

7. AGE: ...Yrs. ...Mos. ...ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Granite, Ida.

10. NAME OF FATHER: Dean F. Rooks

11. BIRTHPLACE OF FATHER (State or Country): Me

12. MAIDEN NAME OF MOTHER: Frances E. Ames

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. Rooks Rooks.
(Address) Granite, Ida.

15. Filed July 8 1920 FLOYD G. WENDLE Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21. 1920, to June 21. 1920
that I last saw her alive on June 21. 1920
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Atelectasis of Lungs

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary): Premature birth
(Duration) ... yrs. ... mos. ... ds.

(Signed) Frank Kemp M. D.
6/21/1920 (Address) Rathdrum, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Athol | DATE OF BURIAL: June 22 1920

20. UNDERTAKER: O W Eaton | ADDRESS: Rathdrum Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 265
File No. 30795
Registered No. 22

1. PLACE OF DEATH
County of Bonner
City of Newport Idaho (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Duncan McDonell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH June 19 1843
June 19 1926
(Month) (Day) (Year)

7. AGE 77 Yrs. 6 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ed McDonell
(Address) Newport Idaho

15. Filed July 1 1926 C. P. Gethsell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 19 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1920, to June 19 1920
that I last saw him alive on June 19 1920
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Asthma
Chronic interstitial nephritis
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. T. Phillips M. D.
June 20 1920 (Address) Newport Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
[illegible] Wash.	

20. UNDERTAKER	ADDRESS
Wm Davis	Newport Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30796
Registered No. 107

Registration District No. 73
Primary Registration District No. 2170

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vernon Eugene Dixon
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 26 (Day) 1920 (Year)

7. AGE: Yrs. ..... Mos. 14 ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): /

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Ben Dixon

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Margaret Dennen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. M. Dennen
(Address) Idaho Falls

15. Filed 7/19 1920 — W. E. Kunnard, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1920, to July 10 1920
that I last saw h.im alive on July 7 1920
and that death occurred on the date stated above, at 6:30 M.

The CAUSE OF DEATH* was as follows:

Premature Child
Malnutrition - Convulsions

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
7/11 1920 (Address) W. E. Wilbur

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. 14 days
Where was disease contracted if not at place of death? .....
Former or usual residence Idaho Falls

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: July 1 1920

20. UNDERTAKER: Taylor - Kinsman Und. Co. — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30797
Registered No. 108

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
Registration District No. 23
Primary Registration District No. 2110

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henriette Schwarze

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. ~~SEX~~ Female
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married
6. DATE OF BIRTH April (Month) 29 (Day) 1861 (Year)
7. AGE 59 Yrs. 7 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country) Mo.
10. NAME OF FATHER Henry Schatte
11. BIRTHPLACE OF FATHER (State or Country) Germany
12. MAIDEN NAME OF MOTHER ? Hase
13. BIRTHPLACE OF MOTHER (State or Country) Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry J. Schwarze
(Address) R 2 Rigby Ida
15. Filed July 16 1920 C W Kinnaird Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 14 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 1:19 M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C C Dunwoody M.D.
7/16 1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence ..... Ship

19. PLACE OF BURIAL OR REMOVAL Hoberg Mo. | DATE OF BURIAL 7-16 1920
20. UNDERTAKER C C Dunwoody | ADDRESS Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 7 0
File No. 30798
Registered No. 1 0 7

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia Matilda Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: July (Month) 5 (Day) 1867 (Year)

7. AGE: 63 Yrs. ..... Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Jno Curtis Taunton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Jane Barnaby

13. BIRTHPLACE OF MOTHER (State or Country): Eng Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pope Smith
(Address) Idaho Falls

15. Filed 7/16 1920 C. A. Finnand Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to July 13 1920
that I last saw h[illegible] alive on July 13 1920
and that death occurred on the date stated above, at 2.30 M.
The CAUSE OF DEATH* was as follows:

Arteri Sclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. C. Clemens M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Idaho Falls

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Rose Hill Cemetery | DATE OF BURIAL: July 16 1920

20. UNDERTAKER: Taylor-Edwards Und. Co | ADDRESS: Idaho Falls.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30800

Registered No. 1092

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 3102

(No. Spencer St. Hosp. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Hare

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: March 17 1873 (Month) (Day) (Year)

7. AGE: 47 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ino.

10. NAME OF FATHER: Wm Jenny

11. BIRTHPLACE OF FATHER (State or Country): Wisc.

12. MAIDEN NAME OF MOTHER: Sarah Clark

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. H. Hare

(Address) Idaho Falls

15. Filed July 12 1920 W. Kramond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 15 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1920, to June 15 1920 that I last saw her alive on June 14 1920 and that death occurred on the date stated above, at 7 M.

The CAUSE OF DEATH* was as follows:

Embolism following operation for hysterectomy for myoma Uterus 8 days previous.

2-3 min (Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. Kramond M. D.

7/12 1920 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rose Hill Idaho Falls DATE OF BURIAL June 17 1920

20. UNDERTAKER Cliff Hagen ADDRESS Idaho Falls

Dr. Spencer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 [illegible].

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No. 2130
File No. 30801
Registered No. 104

1. PLACE OF DEATH
County of Bonneville
City of Salt Lake
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessie M Cook.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 27 1919 (Month) (Day) (Year)

7. AGE: 1 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: no.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): near Idaho Falls.

10. NAME OF FATHER: Henry Cook.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emily F Newman.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H E Cook.
(Address) Reg by.

15. Filed July 12 1920 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 6, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 5, 1920 to May 6 1920 that I last saw h[illegible] alive on May 5, 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Erysipelas
(Duration) 1 Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O. Mellon M. D.
1919 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby, Idaho. DATE OF BURIAL: May 7 1920.

20. UNDERTAKER: Griffeth Bros. ADDRESS: Idaho Falls.

Dr. Mellon

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30802

Registered No. 103

1. PLACE OF DEATH.

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. Ward 1

(No. 455 E. 4th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Monzono.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 22nd (Day) 1920. (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls, Idaho

10. NAME OF FATHER Daikichi Monzono.

11. BIRTHPLACE OF FATHER (State or Country) Japan

12. MAIDEN NAME OF MOTHER Yukino Monzono.

13. BIRTHPLACE OF MOTHER (State or Country) Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Idaho Falls, Idaho

15. Filed July 12 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22nd (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920, to ..... 191..., that I last saw h[illegible] alive on June 20 1920 and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H S Spence M. D.

July 11 1920 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls — DATE OF BURIAL: June 24 1920

20. UNDERTAKER: Stafford Hayes — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS & ENRS. 24858

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30803

Registered No. 102

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 24-1-a

(No. Walnut St. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leland C. Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: Feb. (Month) 13 (Day) 1867 (Year)

7. AGE: 53 Yrs. 8 Mos. 10 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Banker

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Campbell

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Rose Campbell

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cliff C. Hayes

(Address)

15. Filed 7/12 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1920, to June 23 1920, that I last saw h.. alive on June 22 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gunshot wound of head - Self-inflicted.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Wilson M. D.

7/12/1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls — DATE OF BURIAL: June 25 1920

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

Dr. Wilson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 7 21 10
File No. 3084
Registered No. 101

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fenton Roy Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Apr. (Month) 16. (Day) 1 20. (Year)

7. AGE: ..... Yrs. ..... Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: No.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wyom.

10. NAME OF FATHER: Albert Hill

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Florence Andrus

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cliff C Hayes
(Address) Idaho Falls

15. Filed Jan 12 1920 W Hammond Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 1920, to April 28 1920, that I last saw him alive on April 28 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jabez W West M. D.
19..... (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ucon, Ida. DATE OF BURIAL: May 3 1920

20. UNDERTAKER: Cliff Hayes ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Dr. West.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2102
File No. 30805
Registered No. 700.

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Belle Brosius

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 24 (Day) 1860 (Year)

7. AGE: 59 Yrs. 11 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: J G Robinson

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mark Brosius
(Address) Ida Falls

15. Filed July 1 1920 W Townsend Local Registrar
Dr Spencer

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1920, to — 19—
that I last saw h[illegible] alive on May 4 1920
and that death occurred on the date stated above, at 10 A M.
The CAUSE OF DEATH* was as follows:
Carcinoma of maxilla

[redacted] (Duration) Yrs. 8 mos. ds.
Contributory (Secondary) (Duration) yrs. mos. ds.

(Signed) H D Spencer M. D.
5/19 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida — DATE OF BURIAL: 5/20 1920

20. UNDERTAKER: C E Townsend — ADDRESS: Ida Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 30806
Registered No. [illegible]

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Woodford Skeen Rogers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: March (Month) 15 (Day) 1863 (Year)

7. AGE: 57 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Chauncey D Rogers

11. BIRTHPLACE OF FATHER (State or Country): Ills.

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cecil W Rogers
(Address) Mesa, Arizona

15. Filed June 21 19 20 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1920, to June 11 1920
that I last saw h[illegible] alive on June 11 19..,
and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach (?)

..... (Duration) 1 Yrs. — mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A M Palmer M. D.
6/14 1920 (Address) Rigby Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Idaho

19. PLACE OF BURIAL OR REMOVAL: Mesa Arizona — DATE OF BURIAL: 6/15 1920

20. UNDERTAKER: C C Dunwoody — ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 1 7 0
File No. 30807
Registered No. 97

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Blanche Dalton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: May (Month) 3 (Day) 919 (Year)

7. AGE: ..... Yrs. 9 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION: —
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: M E Dalton

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Edna Hyde

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M E Dalton
(Address) Idaho Falls

15. Filed 6/21 1920 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920 to Feb 20 1920 that I last saw h[illegible] alive on Feb 20 1920 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Meningitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

6/21 1920 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 7-22-1920

20. UNDERTAKER: C C Sherwood — ADDRESS: Idaho Falls

Dr Shupe

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2120
File No. 30808
Registered No. 96

1. PLACE OF DEATH
County of Bonneville
City of Ammon
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Black
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Child

6. DATE OF BIRTH: March (Month) 10 (Day) 1919 (Year)

7. AGE: 1 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm S Black

11. BIRTHPLACE OF FATHER (State or Country): Verna Johnson not Mexico

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E W Johnson Sr.
(Address) Idaho Falls

15. Filed 6/21 1920 [illegible] Local Registrar
Dr Heat

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feby (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 20 1920 to Feb 21 1920 that I last saw h[illegible] alive on Feb 21 1920, and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:

Pneumonia Bronchial

(Duration) — Yrs. — mos. 14 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Gaby Hoskins M. D.
(Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ammon — DATE OF BURIAL: Feb 22 1920

20. UNDERTAKER: B G Linwood — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21 V 70
File No. 30809
Registered No. 9 V -

1. PLACE OF DEATH
County of Bonneville
City of Milo
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josetta Freeman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 18 1900 (Month) (Day) (Year)

7. AGE: 19 Yrs. 11 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Darwin Chidester

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Caroline Gubler

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John O'Neeman
(Address) Idaho Falls

15. Filed June 21 19 20 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 2 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1 1920 to March 2 1920 that I last saw her alive on Mar 1 1920 and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Influenza Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jabez W. Post M. D.

3/5 1920 (Address) Idaho Falls.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Milo, Ida — DATE OF BURIAL: 3/6 1920

20. UNDERTAKER: [illegible] Lunwoodey — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

30811

Registration District No. 73
Primary Registration District No. 2 1 1 0
File No.
Registered No. 93

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Perraud
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: May (Month) 1st (Day) 1851 (Year)

7. AGE: 69 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Valentine Thompson

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Mary A King

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Bertha
(Address) Idaho Falls

15. Filed 6/21 1920 C Kennard
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 9a M.
The CAUSE OF DEATH* was as follows: Cirrhosis
Yrs Medical attendance

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C Kennard M. D.
5/15 1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 5/15 1920

20. UNDERTAKER: C C Dunwoody — ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 30812
Registered No. 92

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Sheilds
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct 31 1899 (Month) (Day) (Year)

7. AGE: 20 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): utah

10. NAME OF FATHER: Virgil A Nelson

11. BIRTHPLACE OF FATHER (State or Country): N. C

12. MAIDEN NAME OF MOTHER: Ida E McCammar

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Ida E Sheilds
(Address): Idaho Falls

15. Filed June 21 1920 W. H. Linnell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 20 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1920, to June 20 1920, that I last saw h~~er~~ alive on June 20 1920, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus

(Duration) 2 Yrs. 2 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H V Hatch M. D.
6/20 1920 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Soda Utah | DATE OF BURIAL: 6/20 1920

20. UNDERTAKER: C. E. Sherwood | ADDRESS: Ida Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 4 0
File No. 30814
Registered No. 90

1. PLACE OF DEATH
County of Bonneville
City of Iona
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Lindholm
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Apr. (Month) 24 (Day) 1873 (Year)

7. AGE: 47 Yrs. 0 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tooele, Utah

10. NAME OF FATHER: Carl Eric Lindholm

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Johanna Nielsen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alma Lindholm
(Address) Iona, Ida

15. Filed 6/21 1920 [illegible]
Local Registrar
D. Thorpe

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1920, to May 22 1920, that I last saw h— alive on May 22 1920, and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Flu
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. R. Shafer M. D.
1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 5/25 1920

20. UNDERTAKER: [illegible] Greenwood — ADDRESS: Ida Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2117
File No. 30815
Registered No. 49

1. PLACE OF DEATH,
County of Bonneville
City of Idaho Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME R Furuda

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept 20 d (Month) (Day) 1896 (Year)

7. AGE: 23 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: Raizo Furuda

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Oshino

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. Ito
(Address) Ryburg

15. Filed 6/21 1920 W. Summers Local Registrar
Dr Shupe

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1920 to May 10 1920, that I last saw h— alive on May 10 1920, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Shupe M. D.

1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Ship.

19. PLACE OF BURIAL OR REMOVAL: Thornton, Ida — DATE OF BURIAL: 6/11 1920

20. UNDERTAKER: E C Dunwoody — ADDRESS: Ida Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 30816
Registered No. 44

1. PLACE OF DEATH
County of Bonneville
City of Ucon
(No.) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucile Chapple
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: March 22 (Month) (Day) 1918 (Year)

7. AGE: 1 Yrs. 7 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Chapple

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Williams

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Chapple
(Address) Rigby Rt 2 Ida

15. Filed 6/21 1920 W Hammond Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 20 1920, to March 22 1920 that I last saw her alive on March 22 1920, and that death occurred on the date stated above, at 8 9 M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) Yrs. — mos. 3 ds.

Contributory (Secondary) Chronic Cholecystitis

(Duration) yrs. 1 mos. 3 ds.

(Signed) Jabez West M. D.

3-23 1920 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ucon, Ida — DATE OF BURIAL: 6/10 1920

20. UNDERTAKER: C E Simmonds — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

D. Neat

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 1213
File No. 30817
Registered No. 83

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls
(No. Spencer Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Harold Murphy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: February (Month) 26 (Day) 1849 (Year)

7. AGE: Yrs. 71 Mos. 3 ds. 23
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: Wm. E. Murphy

11. BIRTHPLACE OF FATHER (State or Country): South Carolina

12. MAIDEN NAME OF MOTHER: Mary Reed

13. BIRTHPLACE OF MOTHER (State or Country): Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Murphy
(Address) Bayley Ida R#2

15. Filed June 21 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1919, to June 18 1920
that I last saw him alive on June 18 1920
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Cancer, stomach & liver.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. O. Jones M. D.
June 18 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 3 mos. days. In the State 27 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Shelton Idaho

19. PLACE OF BURIAL OR REMOVAL: Shelton Cemetery — DATE OF BURIAL: June 21 1920

20. UNDERTAKER: Taylor-Kinnear Undertaking Co. — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30818
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 29
Primary Registration District No. 2156
(No. ....., ... St.)

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. May (Month) 24 (Day) 1864 (Year)
7. AGE: 56 Yrs. ..... Mos. 26 ds.
IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Sweden
10. NAME OF FATHER: Johnson
11. BIRTHPLACE OF FATHER (State or Country): Sweden
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): Sweden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Selden Wright
(Address) .....
15. Filed June 21 1920. E E Fry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 20 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to June 20 1920
that I last saw h.. alive on June 20 1920
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) E E Fry M. D.
6/21 1920 (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Paradise Cemetery — DATE OF BURIAL: June 22 1920
20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30819
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79
Primary Registration District No. 2156
(No. ....., ... St.)

2. FULL NAME Doris Loretta O'Keefe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April (Month) 23 (Day) 1919 (Year)

7. AGE: 1 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John O'Keefe

11. BIRTHPLACE OF FATHER (State or Country) N. D.

12. MAIDEN NAME OF MOTHER Barbara Martha Chevrancs

13. BIRTHPLACE OF MOTHER (State or Country) N D

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed June 21st 1920. ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1920 to June 20 1920
that I last saw h[illegible] alive on June 20 1920
and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Membranous Croup

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
6/21 1920. (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Ida — DATE OF BURIAL June 22 1920

20. UNDERTAKER H Stookey — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30820
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 29
Primary Registration District No. 2156

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cleo Wilbur Simmons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Apr (Month) 29 (Day) 1900 (Year)

7. AGE: 20 Yrs. ..... Mos. 22 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Motorman
(b) General nature of industry, business, or establishment in which employed (or employer): Lumber yrd.

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Lewis Simmons

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Emma Jones

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mayo Simmons
(Address) Moravia Ida

15. Filed June 20 1920 .....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:
Neck Broken due to accident
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) C. D. Simmonds Coroner M. D.
.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days, In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moravia Ida
DATE OF BURIAL: May 21 1920

20. UNDERTAKER: J. L. Stookey
ADDRESS: Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. [illegible]
Primary Registration District No. 2129
File No. 30821
Registered No.

1. PLACE OF DEATH
County of Butte
City of Moore
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Chester Harper
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 21 (Day) 1868 (Year)

7. AGE: 53 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Mill creek Utah

10. NAME OF FATHER: John Herbst

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Pitmore

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chester Harper
(Address) Moore, Idaho

15. Filed 6/28 1920 E. W. Fox Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/26 1920, to 6/26 1920
that I last saw her alive on 6/26 1920
and that death occurred on the date stated above, at 4:10 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy

2 hrs (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. W. Fox M. D.
6/26 1920 (Address) Arco, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moore, Idaho
DATE OF BURIAL: 6/28 1920

20. UNDERTAKER: Lon Kruse
ADDRESS: Moore, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30822
Registered No.

1. PLACE OF DEATH
County of Butte
City of Darlington
(No. ..... St.)
Registration District No. 59
Primary Registration District No. 2129
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl Coleman Harris
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 23 (Day) 1898 (Year)

7. AGE: 22 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Marysville, Idaho

10. NAME OF FATHER: James Campbell Harris

11. BIRTHPLACE OF FATHER (State or Country): Richmond, Utah

12. MAIDEN NAME OF MOTHER: Francetta Coleman

13. BIRTHPLACE OF MOTHER (State or Country): Smithfield Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francetta Harris
(Address) Darlington, Idaho

15. Filed 6/18 19 20 — E W Fox, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 18 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19 ..... to — 19 .....
that I last saw h..... alive on — 19 .....
and that death occurred on the date stated above, at 3:30 P. M.
The CAUSE OF DEATH* was as follows:
Drowned in irrigation ditch accidentally (Coroner's)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E W Fox M. D.
6/18 19 20 (Address) Arco, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Darlington, Idaho — DATE OF BURIAL: 6/21 19 20

20. UNDERTAKER: Carlson — ADDRESS: Darlington Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30823
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 59
Primary Registration District No. 12179
(No. ....., ... St.)

1. PLACE OF DEATH
County of Butte
City of Arco
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Steven Van Rancheler Grosbeck

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: March 7 1891 (Month) (Day) (Year)
7. AGE: 29 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many .... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Springfield Utah.
10. NAME OF FATHER: J. A. Grosbeck.
11. BIRTHPLACE OF FATHER (State or Country): Iowa.
12. MAIDEN NAME OF MOTHER: Lottie Hill
13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S B Grosbeck
(Address) Moore
15. Filed 6/7 1920 S. D. Paulson Local Registrar.
For C. W. Fox

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 7 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 5 1920 to June 7 1920 that I last saw him alive on June 7 1920 and that death occurred on the date stated above, at 6.10 A. M.
The CAUSE OF DEATH* was as follows:
Typhoid pneumonia
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) .....
(Duration) 2 Yrs ..... mos ..... ds.
(Signed) S. D. Paulson M. D.
June 7 1920 (Address) Arco Idaho
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Springfield Utah. DATE OF BURIAL: 6/10 1920
20. UNDERTAKER: H. A. McMann ADDRESS: Pocatello Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Idaho

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon — Registration District No. 9

City of Caldwell — Primary Registration District No. 2005

(No. ..... , ... St.)

File No. 30824

Registered No. 94

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Robson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 2 (Day) 875 (Year)

7. AGE: 45 Yrs. 6 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thomas A. Robson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Lucretia C Lovell

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jess Robson

(Address) Caldwell- Idaho

15. Filed July 9 — 1920 — John L Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1920, to July 8 1920, that I last saw h. alive on July 8 1920, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Blood Poison & Shock following Comp. Fracture Leg & amputation

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) Comp. fracture Leg,

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H L Storms, M. D.

July 8 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30825
Registered No. 93

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lea Douglas Stafford
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 24 (Day) 1840 (Year)

7. AGE: 80 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Dan't. Mason

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. W. Stafford
(Address) Route 1 Box #1

15. Filed July 9 – 1920 John S. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 19 1920 to July 2 1920
that I last saw h[illegible] alive on June 30 1920
and that death occurred on the date stated above, at 4-30 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of liver

(Duration) Yrs. 4 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. M. Coen M. D.
7/8 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill Cem. DATE OF BURIAL: 7-9 1920
20. UNDERTAKER: [illegible] Peckham ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30826
Registered No. 92

1. PLACE OF DEATH
County of Canyon
City of Huston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie S Sheets
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 6 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Jno. F. Sheets

11. BIRTHPLACE OF FATHER (State or Country) New Jersey

12. MAIDEN NAME OF MOTHER Mary E. Doan

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno F. Sheets
(Address) Huston Ida R.1.

15. Filed July-8-1920 John L. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1920, to July 7- 1920 that I last saw h[illegible] alive on July 7- 1920, and that death occurred on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:

Open Congestion Ovelby (Blue baby)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Spasemo-
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John L. Meyer M. D.
7-8-1920 (Address) Caldwell- Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Huston Ida
DATE OF BURIAL: 7-8 1920

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30827
Registered No. 97

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Edward Shaver
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Aug 7 1906 (Month) (Day) (Year)

7. AGE: 13 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: D. H. Shaver

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Estella Amack

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. H. Shaver
(Address) Nampa #3

15. Filed 7-6- 1920 — John S. Mayes, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Perforating Gunshot Wound Thorax - Central Mediastinal Space
(Duration) ..... Yrs. ..... mos. 0 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S. B. Dudley M. D.
7-6 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian - Idaho — DATE OF BURIAL: July 6-1920
20. UNDERTAKER: C. J. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30828
Registered No. 90

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Russel McCollum
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widower

6. DATE OF BIRTH: April 10 1849 (Month) (Day) (Year)

7. AGE: 71 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Rufus McCollum

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nora Mal Dennerline
(Address)

15. Filed 7-2-1920 John P. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 30 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1920 to June 30 1920
that I last saw him alive on June 30 1920
and that death occurred on the date stated above, at 11 A M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Mason M. D.
7/1 1920 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 7-2 1920

20. UNDERTAKER: Beckham ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30829
Registered No. 87

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Stebbins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	

6. DATE OF BIRTH: June (Month) 23 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. H. Stebbins

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Vena Kirk

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Stebbins
(Address) Caldwell, Ida.

15. Filed 6-28- 1920 John S. Meyers - Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1920 to June 27 1920
that I last saw him alive on June 27 1920
and that death occurred on the date stated above, at 1-30 P.M.
The CAUSE OF DEATH* was as follows:
Births Paralysis
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. H. Davey M. D.
19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	6/28 1920
20. UNDERTAKER	ADDRESS
C. C. Peckham	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30830
Registered No. 38

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Riley Vinson Rickman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 20 (Day) 1920 (Year)

7. AGE: ..... Yrs. 5 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Andrew L Rickman

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Inez Dorman

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Inez Rickman
(Address) Caldwell

15. Filed 6-27-1920 John L Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Whooping cough.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Colal,
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. V. Peckham Coroner M.D.
6/27 1920 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: June 28 1920

20. UNDERTAKER: Cole
ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30831
Registered No. [illegible]

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Levi Swarner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH ..... (Month) ..... (Day) ..... 1 (Year)

7. AGE 20 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Ranchhand
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Don't Know

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. S. Stevenson
(Address) Caldwell, Ida.

15. Filed 6-24- 1920 John L. Morgan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1920, to June 21 1920
that I last saw him alive on June 21 1920,
and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Ruptured appendix
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) P. G. Young M. D.
6/22 1920 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Stevenspoint, Wisc.	19 .....
20. UNDERTAKER C. V. Peckham	ADDRESS Caldwell, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 1005
File No. 30832
Registered No. 86

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Bell Halford
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Divorced

6. DATE OF BIRTH: March (Month) 29 (Day) 1861 (Year)

7. AGE: 59 Yrs. ..... Mos. 2 ds. 28
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Elliott

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rutledge

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jay Harrison
(Address) Caldwell Ida.

15. Filed 6-23-1920
John S. Meyer
Local Registrar.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 28 1920, to June 22 1920, that I last saw her alive on June 22 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Carcinoma of the Uterus.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. F. Hunt M.D.
June 23, 1920. (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: June 25 1920

20. UNDERTAKER: Coe Funeral Co. — ADDRESS: Caldwell Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2004
File No. 30833
Registered No. 85

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo Washington Spraug

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1856 (Year)

7. AGE: 63 Yrs. 6 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Godfrey Sprang

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Gerhold

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs L. Sprang
(Address): Platteville Colorado

15. Filed 6-22-1920
Jos. S. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1920 to June 20 1920
that I last saw him alive on June 20 1920
and that death occurred on the date stated above, at 10-30 A.M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Tyler M. D.
6-21 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Platteville Colo. | DATE OF BURIAL ..... 19.....
20. UNDERTAKER: C. A. Peckham | ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 1-M. M.-1-19.-

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Wilder

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

File No. 30834

Registered No. 84

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dewey Lee Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

6. DATE OF BIRTH: Sept 7 1897 (Month) (Day) (Year)

7. AGE: 22 Yrs. 9 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranch hand
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: Marion L. Harris

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Jane Gladden

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Joseph E. Harris
(Address): Caldwell Box 273

15. Filed 6-22-1920 John S. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 1-20 P.M.
The CAUSE OF DEATH* was as follows:
Wound in brain, from shot gun

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. V. Peckham Coroner
6-21-1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 6-22-1920

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE 51083

FORM V. S. No. 5-25 M.-1-19.

CERTIFICATE OF DEATH

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

Registration District No. 3-
Primary Registration District No. 2005
State File No.
Local Registrar's No. 5-4-

1. PLACE OF DEATH
County of Canyon
City of Wilder - Idaho
If death occurs away from usual residence, give facts called for under special information.
(No. St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dewey Lee Harris

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single.

6. DATE OF BIRTH: September 7- 1897
(Month) (Day) (Year)

7. AGE: 22 Yrs. 9 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranch hand.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF Father: Marion L. Harris

11. BIRTHPLACE OF FATHER (State or Country): Indiana.

12. MAIDEN NAME OF MOTHER: Zona Gladden

13. BIRTHPLACE OF MOTHER (State or Country): Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph E. Harris
(Address) Caldwell- Idaho- Box 273

15.
Filed 6 - 22 - 1920 John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 18- 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..., to ....., 19...,
that I last saw h... alive on ....., 19...,
and that death occurred on the date stated above, at 1.20 P.M.
The CAUSE OF DEATH* was as follows:
Wound in brain - from
Shot gun -

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. V. Peckham Coroner
19... (Address) Caldwell- Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... ds.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 6-22- 1920

20. UNDERTAKER: C. V. Peckham ADDRESS: Caldwell Idaho-

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 30835
Registered No. 83

1. PLACE OF DEATH
County of Canyon
City of Middleton
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Robert Robinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Married

6. DATE OF BIRTH: Nov. (Month) 29 (Day) 1871 (Year)

7. AGE: 48 Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Chas H. Robinson

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Martha E. Boyd

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. R. Robinson
(Address) Caldwell #1

15. Filed 6-15- 1920 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1919 to Jan 26 1920 that I last saw him alive on Jan 26 1920 and that death occurred on the date stated above, at 4.10 P.M.
The CAUSE OF DEATH* was as follows:
Adenomyocoid & Tuberculosis
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C M Kelley M. D.
6-13 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill	6-15 1920

20. UNDERTAKER	ADDRESS
Beckham	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 3

Primary Registration District No. 1007

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30826

Registered No. 9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Parma

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lloyd V Corson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH. May (Month) 29 (Day) 1846 (Year)

7. AGE: 74 Yrs. ..... Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Retired

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER Peter N Corson

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Do not Know

13. BIRTHPLACE OF MOTHER (State or Country) Do not Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Blanche S. Baston

(Address) Parma Ida

15. Filed June 26 1920 Lucile Hatch Local Registrar

SYMS-YORK CO., PTRS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1920, to June 24 1920, that I last saw him alive on June 24 1920, and that death occured on the date stated above, at 9-30 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary)

Coryza (Duration ..... yrs. ..... mos. 10 ds.

(Signed) W. J. Edwards M. D.

June 26 1920 (Address) Parma Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Roswell — DATE OF BURIAL June 30 1920

20. UNDERTAKER Peckham Fun Co — ADDRESS Parma

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Meridian
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 2004
File No. 30837
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stillborn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wh
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~. (Write the word.)

6. DATE OF BIRTH. June (Month) 15 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 0 hrs. or 7 min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Richard Hook

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City U.

12. MAIDEN NAME OF MOTHER: Mamie Novotny

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed July 10 1920 Pearle Dadds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1920, to June 15 1920, ~~that I last saw him alive on ..... 191~~, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) 0 Yrs. 0 mos. 0 ds.

Contributory (Secondary) .....
(Duration ... Yrs. ... mos. ... ds.

(Signed) Marion L. Funk M. D.
19..... (Address) Nampa Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. | DATE OF BURIAL: June 15 1920

20. UNDERTAKER: None | ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD - RICH CO., PTRS. & ENGRS. 24652

FORM V. S. No. 5A—22 M. 4-20.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006 (No. ..... St.)

File No. 30838

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary F. Venable.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: June 6 1840 (Month) (Day) (Year)

7. AGE: 80 Yrs. — Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tenn.

10. NAME OF FATHER: Joseph Lee

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Sara Reno.

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. Venable

(Address) Nampa Ida.

15. Filed June 15 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1. 1920, to June 13 1920 that I last saw her alive on June 13 1920 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Intestinal carcinoma

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. B. Smith M. D.

6/14 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Meridian Ida. DATE OF BURIAL: June 15 1920

20. UNDERTAKER: F. F. Robinson ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 30896
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. 916 — 13th Ave S St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Wm. Bruce
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Aug (Month) 15 (Day) 841 (Year)

7. AGE: 78 Yrs. 10 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N.Y.

10. NAME OF FATHER: William Bruce

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Masters

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Button
(Address) Nampa Ida

15. Filed June 29 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) — 24 (Day) — 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 26, 1920, to June 23, 1920, that I last saw him alive on June 23, 1920, and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis.
(Duration) Yrs. 6 mos. — ds.
Contributory (Secondary) Enlarged Prostate
(Duration) 1 yrs. — mos. — ds.

(Signed) J. B. Smith M. D.
6/24 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Merrill Wis Canyon — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: H K Robinson — ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
(No. State Sanitarium St.)

File No. 30840
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Montgomery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 33 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) D. O. Boyer
(Address) Nampa Idaho

15. Filed June 29 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1920, to June 24 1920, that I last saw h[illegible] alive on June 24 1920, and that death occured on the date stated above, at 1 [illegible] M.

The CAUSE OF DEATH* was as follows: Suicide by Cutting Throat

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. O. Boyer M. D.

6/24 1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. In the State 6 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Kohlenberg Cem. DATE OF BURIAL: 6/25 191

20. UNDERTAKER: F. R. Coleman ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 7

Primary Registration District No. 2006

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30841

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennie Savery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. 8 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... —

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Burton Savery

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Jennie West

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. A. West

(Address) Nampa, Ida.

15. Filed June 15 1925 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 6 (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-1 1920, to 6-8 1920, that I last saw her alive on 6-8 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

..... (Duration) ..... Yrs. 1 mos. 2 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Robinson M. D.

6-10 1925 (Address) Nampa

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kohlerlawn Cem

DATE OF BURIAL 6/10 1925

20. UNDERTAKER None

ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 30842
Registered No.

1. PLACE OF DEATH.
County of Canyon
City of Nampa (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Stover

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 1 (Day) 1 (Year)

7. AGE: 66 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Virginia

10. NAME OF FATHER Samuel Stover

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Mary Good

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jennie Young
(Address) .....

15. Filed June 16 1920 Pearle Dodds Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 10 (Day) 20 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1920, to June 10 1920, that I last saw him alive on June 10 1920, and that death occured on the date stated above, at 11:30 a. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) ←

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J H Murray M. D.

6/11 1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Valley Cem — DATE OF BURIAL: 6-11 1920

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 30845
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Garrett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May [redacted] (Month) 31 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. A. Garrett

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Ora Bolian

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Garrett
(Address) Nampa Ida

15. Filed July 10 1920 Pearl Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1920, to July 8 1920, that I last saw her alive on July 7 1920, and that death occurred on the date stated above, at 3 a. M.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. S. Fry M. D.
July 8 1920 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Idaho — DATE OF BURIAL: July 9 1920

20. UNDERTAKER: H. E. Robinson — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1854
File No. 30844
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carrie Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH

Oct (Month) 25 (Day) 1850 (Year)

7. AGE

69 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Phillip Jacoby

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Margt Conrad

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs E. B. O'Donnell

(Address) Nampa Ida

15.

Filed July 13 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 10th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1920, to June 10 1920

that I last saw h.e.r. alive on June 10 1920

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Perforated gastric ulcer.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B. Scatt. M. D.

19..... (Address) Nampa, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Rahlelawn Cem — **DATE OF BURIAL** 6/13 1920

20. UNDERTAKER Fred K. Robinson — **ADDRESS** Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 30845
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mildred Mae Dooley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 28 1902 (Month) (Day) (Year)

7. AGE: 18 Yrs. – Mos. – ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... In school
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Washington

10. NAME OF FATHER Fremont Dooley

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER J. M. Nelson

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. Dooley
(Address) Nampa Idaho

15. Filed June 20 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to June 3 1920, that I last saw h... alive on ..... 1920, and that death occured on the date stated above, at about 2 A. M.

The CAUSE OF DEATH* was as follows:
Gangrenous rupture ap-
pend. ? followed by general perito-
nitis 10

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Thos. E. Youngman M. D.
7-7 1920 (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rockbluff Cem — DATE OF BURIAL: 6-6 1920

20. UNDERTAKER: F. H. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1806

(No. ..... , ... St.)

File No. 36846

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. ELLEN N. COLVIN

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH

March (Month) 28 (Day) 1853 (Year)

7. AGE

67 Yrs. 3 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Ministers wife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER John Nesbitt

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Jane Moffett

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Earl M. Patterson

(Address) Nampa, Ida. R. D. #1

15.

Filed July 10 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

6 (Month) — 28 (Day) — 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-28 1920, to 6-28 1920 that I last saw h..... alive on ..... 19..... and that death occurred on the date stated above, at 5:30 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos E. Maguire M. D.

7-7 1920 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn	7-1 1920
20. UNDERTAKER	**ADDRESS**
H. Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30847
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.
Registration District No. 7
Primary Registration District No. 2052
(No. , St.)

2. FULL NAME A. G. Lawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6. DATE OF BIRTH: Jan (Month) 4 (Day) 1854 (Year)

7. AGE: 65 Yrs. 7 Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs A. G. Lawson
(Address): Homedale Ida

15.
Filed July 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1920 to July 5 1920
that I last saw h[illegible] alive on July 5 1920
and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:
Chronic Bronchitis
(Duration) Yrs. mos. ds.
Contributory (Secondary) Acute Indigestion
(Duration) yrs. mos. 8 ds.
(Signed) Simpson Hobbs M. D.
19 (Address) Homedale Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fruitdale Cem — DATE OF BURIAL: July 8 1920
20. UNDERTAKER: Fred H. Richmond — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51067

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 30848
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Lawler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. [redacted], MARRIED, [redacted] DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Mar (Month) 5 (Day) 1849 (Year)

7. AGE: 71 Yrs. 3 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montgomery Co Ill

10. NAME OF FATHER: Henry Casey

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Elizabeth Kirk

13. BIRTHPLACE OF MOTHER (State or Country): Illinois Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. C. Tobias
(Address) 904 12th Ave S Nampa Ida

15.
Filed June 25 1925 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1920 to June 19 1920 that I last saw her alive on June 19 1920 and that death occurred on the date stated above, at 1/9 M.
The CAUSE OF DEATH* was as follows:
Pneumonia
..... (Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Measles
..... (Duration) ..... yrs. ..... mos. 5 ds.
(Signed) H P Ross M. D.
June 1920 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wohlerlawn — DATE OF BURIAL: June 20 1920

20. UNDERTAKER: F. M. Robinson — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2002
File No. 30849
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Washington Lawler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. [redacted], MARRIED, [redacted] OR [redacted]: Married (Write the word.)

6. DATE OF BIRTH: [illegible] (Month) 7 (Day) 1878 (Year)

7. AGE: 71 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fayette Co., Ill.

10. NAME OF FATHER: Josiah Lawler

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. C. Gobin
(Address) 904 12th Ave S Nampa

15. Filed June 25 1920 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1920 to June 19 1920
that I last saw him alive on June 19 1920
and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:
Cardiac dilatation
2 hrs.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Measles
(Duration) ..... yrs. ..... mos. 5 ds.
(Signed) H P Ross M. D.
June 22 1920 (Address) Nampa, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: F. V. Robinson — DATE OF BURIAL: June 22 1920

20. UNDERTAKER: F. V. Robinson — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 30850
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lida M Bumgarner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Married

6. DATE OF BIRTH: Oct (Month) 11 (Day) 1866 (Year)

7. AGE: 54 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Mc Pherson

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Calvert

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dorothy Bumgarner
(Address) Nampa Ida

15. Filed July 10 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19—, to ——— 19—
that I last saw her alive on June 1920
and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Acute dilitation of heart.

(Duration) — Yrs. — mos. / ds.

Contributory (Secondary) Chronic valvular insufficiency (Duration) 18 yrs. — mos. — ds.

(Signed) Jas. D. A. Kellogg M. D.
7-10-1920 (Address) Nampa Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	7-10-1920
20. UNDERTAKER	**ADDRESS**
Fred K. Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30851

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Nampa

Registration District No. 7

Primary Registration District No. 2004

(No. 504 State Sanitarium St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Del Culpepper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) (Year): 1911

7. AGE: 9 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: O O Culpepper

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. T. Boyne

(Address) Nampa Idaho

15. Filed July 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) July (Day) 1 (Year) 1920

17. I HEREBY CERTIFY, That I attended deceased from Feby 14 1920, to July 1 1920, that I last saw h[illegible] alive on July 1 1920, and that death occured on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D. T. Boyne M. D.

19..... (Address) Nampa Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 4 mos. 14 days In the State 9 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence ..... Nampa Idaho

19. PLACE OF BURIAL OR REMOVAL: Nampa Idaho — DATE OF BURIAL: 7-10 1920

20. UNDERTAKER: J K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 30852
Registered No. 429

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo C Jones

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 18 (Day) 1887 (Year)

7. AGE: 33 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hooper Utah

10. NAME OF FATHER: Thomas M. Jones

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Phoebe Watts

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. L. Stokes
(Address) Burley Idaho

15. Filed June 26 1920 J. C. Pattison Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Suicide
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. B. Soloway Coroner ~~M. D.~~
6-26-1920 (Address) Burley

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: June 28 1920

20. UNDERTAKER: Rudduck — ADDRESS: Burley Ida

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

Patterson

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30853

Registered No. 430

Registration District No. 117

Primary Registration District No. 2196

1. PLACE OF DEATH.

County of Cassia

City of Burley

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William A. Tolman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Aug. 28 (Month) (Day) 1857 (Year)

7. AGE: 69 Yrs. 9 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Lyrus Tolman

11. BIRTHPLACE OF FATHER (State or Country) Maine

12. MAIDEN NAME OF MOTHER Unknown.

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. A. Tolman
(Address) Oakley Ida.

15.
Filed 6-28 1920 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1920, to June 25 1920, that I last saw him alive on June 25 1920, and that death occured on the date stated above, at 10:40 P.M.

The CAUSE OF DEATH* was as follows:
Rheumatism

(Duration) 7 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Bronchitis

(Duration ..... yrs. 3 mos. ..... ds.

(Signed) J. C. Patterson M. D.

6-26 1920 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Ida.

DATE OF BURIAL: June 28 1920.

20. UNDERTAKER: L. B. Talboy.

ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & RGRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2176
(No. 317, E. 3rd St, Burley Ida St.)

File No. 30854
Registered No. 75

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Marie Morris.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Aug. (Month) 17 (Day) 1898 (Year)

7. AGE
22 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) France.

10. NAME OF FATHER: Joseph Marie

11. BIRTHPLACE OF FATHER
(State or Country) France.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John B. Morris.
(Address) 317 E. 3rd St. Burley

15.
Filed 6-21 1920 Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 20 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Fracture of Skull
Auto Accident.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) L. B. Galloway Coroner M. D.
6-20 1920 (Address) Burley Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: June 23 1920.

20. UNDERTAKER: L. B. Galloway. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

File No. 30855
Registered No. 432

1. PLACE OF DEATH.
County of Cassia.
City of Burley.
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Genevieve Stanley.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: French
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April 11th 1920 (Month) (Day) (Year)

7. AGE ..... Yrs. One Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Burley, Idaho.

10. NAME OF FATHER George Stanley.

11. BIRTHPLACE OF FATHER (State or Country) Kentucky.

12. MAIDEN NAME OF MOTHER Rose Morgan

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo Stanley
(Address) Burley, Idaho.

15. Filed June 2 1920 Dr. J. C. Patterson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Unknown,
Found dead in Bed By parents
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) L. B. Gallogly Coroner M. D.
June 2 1920. (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Idaho. DATE OF BURIAL: June 3rd 1920.

20. UNDERTAKER: L. B. Gallogly. ADDRESS: Burley Ida.

DISINTERMENT PERMIT

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Amberline Stanley

now lying buried in Pleasant View Municipal Cemetery, in the City or Town of Burley

County of Cassia State of Idaho, who died on the 2 day of June, 1920 Aged ____ years ____ months

____ days, the cause of death being found dead in bed and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

L. B. Gallaghy, Coroner attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private private or railway conveyance

to another lot same Cemetery in the City or Town of Burley County of Cassia

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Cassia it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho,

permit Issued to: this 21 day of Feb., A.D. 19 55.

W. M. Bevan
Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of Cassia State of Idaho, this 25th day of February 19 55.

James A. Burbidge, M.D.
Health Officer

Form DPH-48019

FORM V. S. No. 5-25 M. 1-16-13

Patterson

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2194
(No. ..... St.)

File No. 30856
Registered No. 423

1. PLACE OF DEATH.
County of Cassia
City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willard Reed Call.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
June (Month) 21 (Day) 1919. (Year)

7. AGE
..... Yrs. 1 1 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... At home.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Wash.

10. NAME OF FATHER
Harold Call

11. BIRTHPLACE OF FATHER
(State or Country) Utah.

12. MAIDEN NAME OF MOTHER
Beatrice Patterson.

13. BIRTHPLACE OF MOTHER
(State or Country) Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harold Call
(Address) R. F. D. # 4. Burley Ida.

15.
Filed June 6 1920 Th. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 20. (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1920, to June 20 1920, that I last saw him alive on June 18 1920. and that death occured on the date stated above, at 8a. M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis

..... (Duration) ..... Yrs. ..... mos. 4 days.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Patterson M. D.
6-21 1920 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: View Ida.
DATE OF BURIAL: June 21 1920.

20. UNDERTAKER: L. B. Talleyg.
ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30857
Registered No. 1874
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

2. FULL NAME Christopher Hadley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Married

6. DATE OF BIRTH. January (Month) 28 (Day) 1856 (Year)

7. AGE 64 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Cornelius Hadley

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Jane Nelson

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Robert Hadley
(Address): Eugene Ore.

15.
Filed June 4 1920. Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920 to June 3rd 1920
that I last saw him alive on June 3rd 1920.
and that death occurred on the date stated above, at 1.1 P. M.

The CAUSE OF DEATH* was as follows:
Appendicitis (Gangrenous)

(Duration) — Yrs. mos. 3 ds.

Contributory (Secondary) —

(Duration) — Yrs. mos. ds.

(Signed) G. H. Cooper M. D.
19.... (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery — DATE OF BURIAL: 6/7 1920

20. UNDERTAKER: Rewatt — ADDRESS: Burley

Cooper

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30858
Registered No. 435

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

2. FULL NAME John Ward Carter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): ~~Single~~

6. DATE OF BIRTH. Nov (Month) 12 (Day) 1919 (Year)

7. AGE: 1 Yrs. 3 Mos. 0 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Leo J. Carter

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Amelia Webb

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Leo J. Carter
(Address): Burley Ida

15. Filed June 12 1920. Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 - 1920 to June 12 1920
that I last saw h.m. alive on June 11 — 1920
and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:
Basilar Meningitis
(Cause?)
(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) G. H. Cooper M. D.
19.... (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hal Cemetery — DATE OF BURIAL: June 13 1920

20. UNDERTAKER: Rowatt — ADDRESS: Burley Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

30860

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 2199
(No. ....., ... St.)

File No. 8474
Registered No. 4

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Oakley

2. FULL NAME James Francis Walker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 22 1861 (Month) (Day) (Year)

7. AGE: 59 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Blacksmith
(b) General nature of industry, business, or establishment in which employed (or employer)... —

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER David Walker

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Eliza Jane Shuck

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Elmer Cranen

15. Filed July 7 — 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1920, to June 18 1920, that I last saw him alive on June 18 1920, and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Injury from fall from horse

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Shock
(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) Isaac L. Evans M. D.
6/20 1920 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho
DATE OF BURIAL: June 20 1920

20. UNDERTAKER: L. B. Galloway
ADDRESS: Burley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTGS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

30861

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Cassia

City of Almo

Registration District No. 12

Primary Registration District No. 2-199

(No. .... St.)

File No. XVII

Registered No. 3

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Woodrow Wilson Cahoon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 15 1919 (Month) (Day) (Year)

7. AGE: 1 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William D Cahoon

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Jessie Richardson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Annie Green

(Address) Almo Ida

15. Filed July 7th 1920 N. A. Price Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 16 — 1920, to May 3, 1920, that I last saw h in alive on May 3, 1920, and that death occured on the date stated above, at 8.30 P M.

The CAUSE OF DEATH* was as follows:

Gathering in throat, Involvement to stomach, Poisoned blood Convulsion

(Duration) ..... Yrs. ..... mos. 2/ ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 1 yrs. 1 mos 18 days. In the State 1 yrs. 1 mos 18 days

Where was disease contracted if not at place of death? .....

Former or usual residence ..... Almo Ida

19. PLACE OF BURIAL OR REMOVAL: Almo Cemetery

DATE OF BURIAL: 5/5 1920

20. UNDERTAKER: None

ADDRESS: .....

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30862

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Elmore

City of Orofino

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2168

(No. ..... St.)

File No.

Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Deatman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: May (Month) 8 (Day) 1853 (Year)

7. AGE: 67 Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER John Deatman

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Peach

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Orey D Crockett

(Address) Orofino, Idaho

15. Filed July 5 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1920, to May 21 1920, that I last saw h... alive on May 21 1920, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus - Carbuncle

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eric J Hommel M. D.

6/7 1920 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Ida	6/25 1920
20. UNDERTAKER	ADDRESS
W A Shaw	Orofino

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30863
Registered No. 36

1. PLACE OF DEATH
County of Clearwater
City of G.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 7168

2. FULL NAME Mary Fiddler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widow

6. DATE OF BIRTH: May (Month) 6 (Day) 1837 (Year)

7. AGE: 82 Yrs. 9 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Geo Adams

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Carley

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Fred Carb
(Address) Grass Ida

15. Filed July 5 1920 J. H. Faulk Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1918 to 1920
that I last saw her alive on Feb 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: General Debility from old age

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Eula M Boswell M. D.
4/2 1920 (Address) Craigmont Ida,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fraser Ida — DATE OF BURIAL: 4/2 1920

20. UNDERTAKER: W A Shaw — ADDRESS: Craigmont

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 30864
Registered No. 37

1. PLACE OF DEATH
County of Clearwater
City of Kuiper (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John B. Collins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: December (Month) 2 (Day) 1874 (Year)

7. AGE: 45 Yrs. 5 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: John Wesley Collins

11. BIRTHPLACE OF FATHER (State or Country): W. Va

12. MAIDEN NAME OF MOTHER: Lydia Rife

13. BIRTHPLACE OF MOTHER (State or Country): W Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Luda H. Collins
(Address) Wallace Idaho

15. Filed July 5 1920 J. M. Faucher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1920 to May 30 1920
that I last saw h... alive on May 30 1920
and that death occurred on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows:
Asphyxia due to hemorrhage + filling up of lung following a crushing injury
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Earle W Horswell M. D.
6/3 1920 (Address) Orofino Ida

*State the Disease Causing Death; or if deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 6/2 1920

20. UNDERTAKER: H. A. Shaw — ADDRESS: Orofino

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 5168
(No. ..... St.)

File No. 30865
Registered No. 38
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julius Meisel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH ? (Month) ? (Day) About 1857 (Year)

7. AGE 63 yrs. ? mos. ? ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino Ida.

15. Filed July 1, 1920 J. M. Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 31, 1919, to June 3 1920 that I last saw him alive on June 1920 and that death occurred on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows:
Suicide by hanging
Was far advanced
With Pulmonary Tuberculosis
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory Insanity
(Secondary)
(Duration) ? yrs. ? mos. ..... ds.
(Signed) H. A. Chase M. D.
6/6 1920 (Address) Orofino Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 5 mos. 3 days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? ?
Former or usual residence Nez Perce Co.,

19. PLACE OF BURIAL OR REMOVAL: The N. P. Sanitarium Cemetery | DATE OF BURIAL: 6/6 1920

20. UNDERTAKER Dan J. Lawson ADDRESS Orofino, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30866

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clark

City of Dubois

(No. ____, ____ St.)

Registration District No. 125

Primary Registration District No. 2203

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catharine Beighly

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: May (Month) 27 (Day) 1844 (Year)

7. AGE: 75 yrs. 10 mos. ____ ds.

IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Samuel Harner

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Martha Miller

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mahlon Beighly
(Address) Dubois Idaho

15.
Filed June 27 1926 C E Jones M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 27 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1926, to June 27 1926, that I last saw h[illegible] alive on June 25 1926, and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

General Dropsy

(Duration) ____ yrs. 1 mos. ____ ds.

Contributory (Secondary) Rheumatism Failing Compensation

(Duration) ____ yrs. several mos. ____ ds.

(Signed) C E Jones M. D.

6/27 1926 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho

DATE OF BURIAL: 6/28 1926

20. UNDERTAKER: None

ADDRESS: ____

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No. 2203
File No. 30867
Registered No.

1. PLACE OF DEATH.
County of Clark
City of Dubois
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alfred Vellenueve

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH Not Known 1
(Month) (Day) (Year)

7. AGE about 50 yrs. mos. ds.
IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) St Eugene Ont. Can

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grant W Soule
(Address) Dubois Idaho

15.
Filed June 26 1920 C E Jones M D
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~191~~, to 191,
that I last saw ~~h~~ alive on 191,
and that death occurred on the date stated above, at about 5 P.M.

The CAUSE OF DEATH* was as follows:

Instantly killed by falling tree

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C E Jones M. D.
6/26 1920 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..yrs..mos..days. In the State..yrs..mos..days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Smad — DATE OF BURIAL: 6-26 1920

20. UNDERTAKER: None ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS—YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 35
Primary Registration District No. 2021
File No. 30868
Registered No.

1. PLACE OF DEATH

County of Elmore
City of Glenns Ferry
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Miles Ernest Brewer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH April (Month) 14 (Day) 1869 (Year)

7. AGE 51 Yrs. 1 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER William J. Brewer

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Katherine Smith

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Brewer
(Address) Glenn's Ferry Idaho

15. Filed June 9 1920 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [redacted] 1918, to June 8 1920, that I last saw him alive on June 1 1920, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 3 Yrs. ... mos. — ds.
Contributory (Secondary) Mining claim

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. W. Davis M. D.
June 9 1920 (Address) Glenn's Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Glenn's Ferry Idaho	June 9 1920

20. UNDERTAKER	ADDRESS
J. W. Packham	Glenn's Ferry Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30869

Registered No. 46

1. PLACE OF DEATH

County of Franklin

City of Preston

(No. ..... St.)

Registration District No. 27

Primary Registration District No. 2719

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene Meikle Hawkes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct. 8 (Month) (Day) 1917 (Year)

7. AGE: 2 Yrs. 9 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Preston

10. NAME OF FATHER: C. E. Hawkes

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Alice Meikel

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. E. Hawkes

(Address) Preston

15. Filed 7/7 1920 D. A. Rutter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 18 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16 1920, to June 18 1920, that I last saw h.. alive on June 18 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Tubercular Meningetes

(Duration) ..... Yrs. 1 mos. 7 ds.

Contributory (Secondary) Tuberculan cervical lymphadenitis

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) A. V. Cutler Jr. M. D.

19..... (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston

DATE OF BURIAL: 6/20 19 20

20. UNDERTAKER: G. A. Lundquist

ADDRESS: Preston

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30870

Registered No. 47

1. PLACE OF DEATH

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27

Primary Registration District No. 2719

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hazen Wendel McKenzie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single

(Write the word.)

6. DATE OF BIRTH: June 25 (Month) (Day) 1920 (Year)

7. AGE: ——— Yrs. 5 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charles McKenzie

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Amelia Sorenson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles McKenzie

(Address) Preston

15. Filed 7/7 1920 D. A. Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 18 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1920, to May 17 1920 that I last saw h.im alive on May 17 1920, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Pertussis

(Duration) ..... yrs. 1½ mos. ..... ds.

(Signed) A. A. Cutler Jr. M. D.

19..... (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: June 19 1920

20. UNDERTAKER: [illegible] Lundquist — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30871
Registered No.

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 190
(No. , St.)

2. FULL NAME William Bruce

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: 70 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed June 17 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 31 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Found Dead, Cause Heart failure

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Brown - Co. Coroner ~~M. D.~~
19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: June 1 1920

20. UNDERTAKER: O. L. Bucknum
ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30872

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1020
(No. , St.)
Registered No.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Dmeitro Kram

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: not known (Month) (Day) 1 (Year)

7. AGE: 26 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Laborer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. L. Jones.
(Address) Emmett Idaho

15.
Filed June 17 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191.....
that I last saw h..... alive on ..... 191....,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Despondent, Suicide
Gunshot wound

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Brown Co. Coroner
June 3 1920 (Address) Montour Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: June 4 1920

20. UNDERTAKER: C. D. Buckenmeyer
ADDRESS: Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30874
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1014
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charlotte Margaret Slater

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Sept (Month) 15 (Day) 1849 (Year)

7. AGE
70 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Benjamin F Robinson

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A B Slater
(Address) Gooding Ida

15.
Filed 7 19 20
F. D. Carey, M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18th 1920, to June 3 1920
that I last saw her alive on June 3 1920
and that death occurred on the date stated above, at 10a.M.
The CAUSE OF DEATH* was as follows:

Cerebral Abscess

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cromwell M. D.
6/3 1920 (Address) Gooding, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Gooding Cemetery
DATE OF BURIAL 6-4-1920

20. UNDERTAKER A E Thompson
ADDRESS Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
File No. 30875
Registered No. 22

1. PLACE OF DEATH.
County of Ida
City of Grangeville
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jacob A Linger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Aug (Month) 10 (Day) 1841 (Year)

7. AGE: 78 Yrs. 10 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Jacob Alinger

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Margaret Nelson

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Jacob Alinger
(Address) Grangeville

15. Filed July 3 1920 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1920, to June 18 1920, that I last saw him alive on June 15 1920, and that death occured on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Valvular heart disease

(Duration) 8 yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

6/19 1920 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: June 19 1920

20. UNDERTAKER: A J Mangg.
ADDRESS: City.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 30876
Registered No. 21

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alex H Orr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. December (Month) 7 (Day) 1865 (Year)

7. AGE: 54 Yrs. 6 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James Orr

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Marvin

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Alex Orr by Calvin Hazlett
(Address) Grangeville Idaho

15. Filed July 1 1920 G. S. Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1920, to ..... 191....., that I last saw h alive on ..... 191....., and that death occured on the date stated above, at about 11 A.M.

The CAUSE OF DEATH* was as follows:
accidentally killed by bursting of emery wheel on gas engine while filing saw -
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. S. Stockton M. D.
6/29 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fair view
DATE OF BURIAL: June 29 1920

20. UNDERTAKER: E. S. Hancock
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30877

Registered No. 20

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME baby Gunnall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 6 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many 5 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Grangeville

10. NAME OF FATHER Robert O Gunnall

11. BIRTHPLACE OF FATHER (State or Country) Washington state

12. MAIDEN NAME OF MOTHER Mary S Mc Clellan

13. BIRTHPLACE OF MOTHER (State or Country) Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Robert O Gunnall

(Address) Grangeville Ida

15. Filed July 1 1920 G S Stockton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1920, to June 7 1920, that I last saw him alive on June 7 1920 and that death occured on the date stated above, at 11 A, M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. S. Stockton M. D.

6/7 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Denver

DATE OF BURIAL: June 7 1920

20. UNDERTAKER: Ed Hancock

ADDRESS: Grangeville

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
(No. ....., ... St.)

File No. 30878
Registered No. 19

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wayne Rudolph Allman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): —

6. DATE OF BIRTH.
March (Month) 24 (Day) 1920 (Year)

7. AGE
..... Yrs. 3 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Grangeville

10. NAME OF FATHER Walter S Allman

11. BIRTHPLACE OF FATHER (State or Country) Lincoln Illinois

12. MAIDEN NAME OF MOTHER Grace Fraser

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W Walter S Allman
(Address) Grangeville Ida

15.
Filed July 2 1920 G S Stockton
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 24— (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1920, to June 24 1920, that I last saw him alive on June 24 1920 and that death occured on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

6/25 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: 6/27 1920

20. UNDERTAKER: E A Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. L30879
Registered No.

1. PLACE OF DEATH

County of Idaho ... District No. ...

City of Ferdinand ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara May Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	married

6. DATE OF BIRTH: Dec. (Month) 7 (Day) 1889 (Year)

7. AGE: 31 Yrs. 2 Mos. 1 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lyon Co. Kansas

10. NAME OF FATHER: Dickson Hinshaw

11. BIRTHPLACE OF FATHER (State or Country): Pickaway Co Mo.

12. MAIDEN NAME OF MOTHER: Ella Williams

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clara Hill
(Address) Ferdinand Idaho

15. Filed Feb. 9 1920 Lee E Adams Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec Feb 7 1920 to Feb 8 1920
that I last saw her alive on Dec Feb 8 1920
and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Death from Pneumonia following Flu and Childbirth

(Duration) ... Yrs. ... mos. 3/4 ds.
Contributory (Secondary) Childbirth
(Duration) ... yrs. ... mos. ... ds.

(Signed) Lee E Adams M. D.
Feb 1920 (Address) Ferdinand

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Westlake Ida	Feb 10 1920

20. UNDERTAKER	ADDRESS
C A Hall	Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 19
Primary Registration District No. 1050
(No. 818 2nd St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30883
Registered No. 40

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Keller

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept- (Month) 12 (Day) 1905 (Year)

7. AGE: 14 Yrs. 9 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: school girl
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Willis Keller

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Bertha Blagrave

13. BIRTHPLACE OF MOTHER (State or Country): Kan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Willis Keller
(Address) Coeur D'Alene Ida.

15. Filed June 7th 1920 Gus Nelson Local Registrar

SYMS - YORK CO., PTRS. & BOES. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to June 6 1920, that I last saw her alive on June 6 1920, and that death occured on the date stated above, at 11-15 a M.

The CAUSE OF DEATH* was as follows:
Double Pneumonia —
(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) influenza
(Duration) yrs. mos. 10 days ds.

(Signed) F. H. Kroeden M. D.
6/6 1920 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 6-7 1920

20. UNDERTAKER: C. Casady — ADDRESS: C'Dalene

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30884

Registered No. 39

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene (No. ..... 4th St.)

Registration District No. 29

Primary Registration District No. 1060

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria E. Crandall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 56 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Music teacher
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Crandall-Salmon

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Franklin Lucas
(Address) .....

15. Filed May 2nd 1920 Gus Nelson Local Registrar

SYMS - YORK CO., PTGS. & SDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 28 1920, to Apr 30 1920, that I last saw her alive on Apr 30 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cardiac Asthma
Nephritis 20 Yrs. 0 years
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Kneeland M. D.
5/1 1920 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos...
Where was disease contracted if not at place of death?.....
Former or usual residence ..... May 2

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. DATE

20. UNDERTAKER: C. Cassedy, C'dAle

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY IN YEARS, MONTHS AND DAYS. CAUSE OF DEATH in plain terms, so that it may be properly classified. Every Physician should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Every Physician is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30885

Registered No. 15

Registration District No. 30

Primary Registration District No. 1051 - 2051

1. PLACE OF DEATH.

County of Kootenai

City of Rathdrum

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carlos W. Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 21 (Day) 1900 (Year)

7. AGE: 20 Yrs. 9 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farm Labor

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) N. D.

10. NAME OF FATHER W. A. Thomas

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Margret Forsha

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. A. Thomas

(Address) Rathdrum Idaho

15.

Filed 7/6 1920. Frank D. Wing Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18. 1920, to June 22. 1920, that I last saw him alive on June 22. 1920 and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Frank D. Wing M. D.

6/23 1920 (Address) Rathdrum, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Ida — DATE OF BURIAL: June 25 1920

20. UNDERTAKER: C. W. Gibson — ADDRESS: Rathdrum Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Coeur D'Alene

Registration District No. 20

Primary Registration District No. 1057

(No. 1014 Seventh St.)

File No. 30886

Registered No. 923

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME GEORGE G. CARLISLE

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE 50 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. L. Showalter

(Address) Cheney Wash.

15. Filed July 2. 1920 D. D. Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Suicide Shot Gun Wound in Head

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Falder Acting Coroner M. D.

..... 19..... (Address) Coeur D Alene, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 20 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	6/22 19 20

20. UNDERTAKER C. P. Mooney ADDRESS C d'A. Ida.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 30887
Registered No. 822

1. PLACE OF DEATH

County of Kootenai
City of Coeurd Alene (No. 1024 7th St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Flossie Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 20 (Day) 1897 (Year)

7. AGE: 23 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: JosephFortin

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: P. Peltzer

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Thompson
(Address) Coeur D'Alene, Ida.

15. Filed July 2 1920 W. W. Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1920 to ..... 19..... that I last saw h.. alive on June 18 1920 and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J O Bryant M. D.
June 21 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 9 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St. Thomas Cemetery
DATE OF BURIAL: 6/21 19 20

20. UNDERTAKER: R B Mooney
ADDRESS: Cda. Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 30888
Registered No. 821

1. PLACE OF DEATH

County of Kootenai
City of Coeur D Alene
(No. Reed Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Leslie Urquhart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: July (Month) 20 (Day) 1887 (Year)

7. AGE: 32 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroad Man
(b) General nature of industry, business or establishment in which employed (or employer): Brakeman O R & N R R.

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: R. D. Urquhart

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary A. Degerman

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. D. Urquhart
(Address) CoeurdAlene, Ida.

15. Filed July 2, 1920 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14. 1920, to June 16 1920
that I last saw h.... alive on June 15 1920
and that death occurred on the date stated above, at 12:15 M.
The CAUSE OF DEATH* was as follows:
Lobar pneumonia Shock following
Hemorrhage Gastric ulcer.
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John O Wood M. D.
June 16 1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 15 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: 6/17/20

20. UNDERTAKER: R. B. Mooney
ADDRESS: Coeur d'Alene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1050
File No. 30889
Registered No. 820

1. PLACE OF DEATH
County of Kootenai
City of Coeur d Alene
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Mary Reed.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 10 (Day) 1847 (Year)

7. AGE: 73 Yrs. ..... Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home life
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Mathias Sommer

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna Sybella Mary Sommer

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas J. Reed
(Address) Coeur d Alene Ida

15. Filed July 2, 1920 L. D. Brennan, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1920, to June 7 1920
that I last saw h.. alive on June 6 1920
and that death occurred on the date stated above, at 3P M.
The CAUSE OF DEATH* was as follows:
Pernicious anemia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John Ward M. D.
June 7 1920 (Address) Coeur d Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oak Lawn Neb — DATE OF BURIAL: June 17 1920

20. UNDERTAKER: Smith & Co — ADDRESS: Spokane Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 30890
Registered No. 819

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. Old Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Barclay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April (Month) 18 (Day) 1852 (Year)

7. AGE: 68 Yrs. 1 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Agent
(b) General nature of industry, business or establishment in which employed (or employer): Fire Insurance.

9. BIRTHPLACE (State or Country): Newark N. J.

10. NAME OF FATHER: Alexander Barclay

11. BIRTHPLACE OF FATHER (State or Country): New Jersey

12. MAIDEN NAME OF MOTHER: Charlotte Hard

13. BIRTHPLACE OF MOTHER (State or Country): New Jersey.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alexander Barclay M. D.
(Address) Coeur d'Alene.

15. Filed July 2 1920 W. W. Greene Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24, 1919, to June 5 1920 that I last saw h.. alive on June 5 1920 and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:

Coronal Thrombosis

(Duration) Yrs. 6 mos. ds.
Contributory (Secondary) Myocardial degeneration
(Duration) 5 Yrs. mos. ds.
(Signed) Alexander Barclay M. D.
6-5 1920 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 6 mos. 1 days. In the State ... yrs. 6 mos. 1 days
Where was disease contracted if not at place of death? St Paul Minn.
Former or usual residence St Paul Minn.

19. PLACE OF BURIAL OR REMOVAL Spokane Wn. DATE OF BURIAL June 6 1920

20. UNDERTAKER R. B. Mooney ADDRESS Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 30891
Registered No. 818

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 803 7th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David G Davies

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 1 (Day) 1859 (Year)

7. AGE: 60 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Charge of Electric
(b) General nature of industry, business or establishment in which employed (or employer): Light Plant

9. BIRTHPLACE (State or Country): Wales England

10. NAME OF FATHER: William Davies

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary Griffeth

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs D G Davies
(Address) Coeur d'Alene

15. Filed July 2 1920 D. D. Brennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19...
that I last saw h... alive on — 19...
and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows: Deceased was dead before arrival of a Physician - Probable cause Cerebral Hem. or Regr
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) J O Bryan M. D.
June 5 1920 (Address) J O Bryan

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State 12 yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: June 4 1920

20. UNDERTAKER: R O Downey ADDRESS: Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Lemhi

City of Leadore

Registration District No. 42

Primary Registration District No. 2153

(No. ....., ... St.)

File No. 30892

Registered No. 6

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME T D Powell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: 4 May. (Month) (Day) 1864 (Year)

7. AGE: 54 Yrs. ..... Mos. 1 ds. 18

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Dodgville, Wis.

10. NAME OF FATHER: Ieuen Powell

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Sarah Williams

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. T D Powell.

(Address) Leadore Idaho

15. Filed 6/25 1920 D B Keller. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 22 June (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1920 to June 22 1920 that I last saw h.. alive on June 22 1920, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

He was thrown from a horse. the horse falling on him injuring spine and crushing his chest

(Duration) — Yrs. — mos. 1 ds.

Contributory (Secondary) none

(Duration) — yrs. — mos. — ds.

(Signed) Irvin B. Keller M. D.

6/24 1920 (Address) Leadore, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Junction Cemetery — DATE OF BURIAL: 6-24-1920

20. UNDERTAKER: W. C. Yochler — ADDRESS: Salmon, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 41

Primary Registration District No. 2116

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30893

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Fremont

City of Salmon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Spades.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Not known (Month) (Day) 1 (Year)

7. AGE: 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Tingley

(Address) Salmon Idaho

15. Filed 7/10 1920 Leola Tolderlip Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 5th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1920 to June 1920 that I last saw her alive on June 4 1920 and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. B. Hutton M. D.

6/7 1920 (Address) Salmon, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery

DATE OF BURIAL: 6-7" 1920

20. UNDERTAKER: Jim C. Jacobs

ADDRESS: Salmon Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2166
(No. ....., ... St.)

File No. 30894
Registered No. .....

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Williams
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Not known (Month) (Day) 1 (Year)

7. AGE: about 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranch Laborer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm C Doebler
(Address) Salmon, Ida.

15. Filed 7/10 1920 Leola Noddings Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 26th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 5 A. M.
The CAUSE OF DEATH* was as follows: Gun Shot
Wound in the abdomen
by the hand of Nick Larsen.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. C. Doebler Coroner M. D.
6-26-1920 (Address) Salmon, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 6-27-1920

20. UNDERTAKER: Wm C Doebler — ADDRESS: Salmon Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 30895
Registered No.

1. PLACE OF DEATH
County of Latah
City of Palouse
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas R. Matthews

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 31st 1919 (Month) (Day) (Year)

7. AGE: 1 Yrs. 5 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Palouse

10. NAME OF FATHER: Albert John Matthews

11. BIRTHPLACE OF FATHER (State or Country): Palouse

12. MAIDEN NAME OF MOTHER: Helen Courey

13. BIRTHPLACE OF MOTHER (State or Country): Not known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Charles Temple
(Address) Palouse Idaho

15. Filed 7/10 1920 Leola Noddings Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 9th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1920, to June 9 1920, that I last saw h[e] alive on June 9 1920, and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F B Wright M. D.

June 19 20 (Address) Palouse

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse Cemetery
DATE OF BURIAL: 6-7" 1920

20. UNDERTAKER: Jno C Doebler
ADDRESS: Palouse

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 30896

1. PLACE OF DEATH
County of Lemhi
City of Salmon (No. ....., ... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Loula Kuny

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 28 (Day) 1877 (Year)

7. AGE: 43 Yrs. 4 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Star Idaho Ada Co.

10. NAME OF FATHER: J. M. Anderson

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Hulda Cloud

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. M. A. Palmer
(Address) Meridian Idaho

15. Filed 7/10 1920 Leola Noddings Deputy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/1 1920, to 6/11 1920, that I last saw h.e alive on 6/10 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Cardiac regurgitation
.....
.....
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Convulsions
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Chas. F. Hamma M. D.
6/14 1920 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL ..... 19.....
20. UNDERTAKER Boise Ida. ADDRESS .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 30897
Registered No. 107

1. PLACE OF DEATH
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Carlson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: April (Month) 12 (Day) 1830 (Year)

7. AGE: 90 Yrs. ..... Mos. 2 ds. 10
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer - Retired.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ole G. Christenson
(Address) Moscow Idaho

15. Filed June 22 1920 W. H. Carruthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Old age - Inanition

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Leitch Health Officer M. D.
June 22 1920 (Address) Moscow - Ida -

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow - Ida -	June 23 1920

20. UNDERTAKER	ADDRESS
E. M. Crum	Palouse

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 30898
Registered No. 104

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ida Moore Gerhardt.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: May (Month) 20 (Day) 1850 (Year)

7. AGE: 70 Yrs. ... Mos. 14 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Alfred Moore.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sophia Seaman

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Wayne S. Snoddy
(Address) Moscow Ida

15. Filed 6/9 1920 W. H. Carruthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4th 1920 to June 6th 1920 that I last saw her alive on June 8th 1920 and that death occurred on the date stated above, at 7:45 P M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart following last confinement
Chronic mitral disease
(Duration) 5 Yrs. ... mos. ... ds.
Contributory (Secondary) High Blood Pressure 233/
(Duration) ... yrs. ... mos. ... ds.

(Signed) F W Hendrickson M. D.
6/9 1920 (Address) Moscow Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kansas City Mo	19

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 30899
Registered No. 103

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chester Marion Thorson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: March (Month) 30 (Day) 1919 (Year)

7. AGE: 1 Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Thorey B. Thorson

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Alma Mary Halvorson

13. BIRTHPLACE OF MOTHER (State or Country): South Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thorey B Thorson
(Address) Moscow Idaho

15. Filed June 4 1920 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 29 1920, to June 3, 1920, that I last saw h.im alive on June 3, 1920, and that death occurred on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) Yrs. 8 mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Wiley M. D.
6/4 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Greenwood Valley Cem — DATE OF BURIAL: 6/5 1920

20. UNDERTAKER: Allen Rice — ADDRESS: Moscow

FORM V. S. No. 5-25 M. 1-19.

[redacted] of Idaho
[redacted] HEALTH
[redacted] Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Troy

If death occurs away from usual residence, give facts called for under special information.

[redacted] Primary Registration District No. 144 File No. 30901

(No. [redacted] St.) Registered No. [redacted]

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Percy Hamner Walker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 23 (Day) 1916 (Year)

7. AGE: 3 Yrs. 11 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Troy Idaho

10. NAME OF FATHER: Thomas Walker.

11. BIRTHPLACE OF FATHER (State or Country): St Francis Arkansas

12. MAIDEN NAME OF MOTHER: Ella Chaney

13. BIRTHPLACE OF MOTHER (State or Country): Troy Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Pearley Chaney

(Address) Troy Idaho

15. Filed June 28 1920 J E Pickerd Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1920, to June 23 1920 that I last saw h[redacted] alive on June 23 1920 and that death occurred on the date stated above, at 1134 A.M.

The CAUSE OF DEATH* was as follows:

Capture Pneumonitis

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) Infected Tonsils following Influenza.

(Duration) — yrs. — mos. 4 ds.

(Signed) C K Henke M. D.

6-27 1920 (Address) Troy Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bethel Idaho — DATE OF BURIAL: 6-25 1920

20. UNDERTAKER: J E Pickerd — ADDRESS: Troy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30902
Registered No.

1. PLACE OF DEATH
County of Latah
City of Potlatch
Registration District No.
Primary Registration District No. 2145
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Cunningham

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 25 (Day) 1920 (Year)

7. AGE: ~ yrs. ~ mos. ~ ds. IF LESS than 1 day how many 9 hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Potlatch Ida.

10. NAME OF FATHER: Fra Joseph Cunningham

11. BIRTHPLACE OF FATHER (State or Country): Belmont Park

12. MAIDEN NAME OF MOTHER: Myrtle Hutchinson.

13. BIRTHPLACE OF MOTHER (State or Country): Reinnis Co Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): father
(Address): Potlatch Ida

15.
Filed June 28 1920 J. W. Thompson Deputy Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1920, to June 26 1920 that I last saw him alive on June 25 1920 and that death occurred on the date stated above, at 4-9 M.

The CAUSE OF DEATH* was as follows:

Asthenia.
(7½ months factus)

(Duration) yrs. mos. ds.

Contributory (Secondary): none

(Duration) yrs. mos. ds.

(Signed) Ernest Stone M. D.
June 25 1920 (Address) Palouse Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs mos ds. In the State yrs mos ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch, Id — DATE OF BURIAL: June 27 1920

20. UNDERTAKER: Parents — ADDRESS: Potlatch, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17149

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 68

Primary Registration District No.

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30903

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Juliaetta

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christopher Fredrick Keefer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Nov (Month) 6 (Day) 1868 (Year)

7. AGE: 51 Yrs. 6 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: ——

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: ——

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Emma M. Keefer

(Address) Juliaetta Idaho

15. Filed 6-3 1920

R. T. Popple
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan- 1920, to June 1st 1920, that I last saw him alive on May 31st 1920 and that death occured on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) Yrs. 7 mos. ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) W. A. Rothwell M. D.

June 1 1920 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Cem

DATE OF BURIAL: 6-3 1920

20. UNDERTAKER: L. Bozeelon

ADDRESS: Juliaetta Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 68

County of Bingham

Primary Registration District No.

City of Basalt (No. , St.)

File No. 30904

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen A Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Sept 25 1919 (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 7 ds. 6

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Juliaetta

10. NAME OF FATHER James J Smith

11. BIRTHPLACE OF FATHER (State or Country) Arkansas

12. MAIDEN NAME OF MOTHER Margarite Myers

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wm G Baker M.D.

(Address) Basalt

15. Filed 6-3 1920 R T Pepple Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 1 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1920, to May 31 1920, that I last saw her alive on May 31 1920, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) —

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm G Baker M. D.

19 ..... (Address) Basalt

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Cem — DATE OF BURIAL: 6-3 1920

20. UNDERTAKER: None — ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 68
Primary Registration District No.
File No. 30905
Registered No.

1. PLACE OF DEATH
County of Latah
City of Kendrick
(No. On highway 3/4 mile from Kendrick)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lester Wood
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb (Month) 29 (Day) 1904 (Year)

7. AGE: 16 Yrs. 3 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo Wood

11. BIRTHPLACE OF FATHER (State or Country): Tex

12. MAIDEN NAME OF MOTHER: Martha Kennedy

13. BIRTHPLACE OF MOTHER (State or Country): Kan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Wood
(Address) Lewiston Idaho

15. Filed June 6 1920 R. F. Peppler Local Registrar
Juliaetta Idaho

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 11:30 P.M.
The CAUSE OF DEATH* was as follows:
Killed by accident - Car rolled over him crushing his head. Died instantly
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. A. Rathwell M. D.
6. 6. 1920 (Address) Kendrick Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lenore Idaho
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: W. Williamson
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 61087

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Kendrick R. 2 -
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 18
Primary Registration District No.
(No. ..., ... St.)

File No. 30966
Registered No.

2. FULL NAME James Russel Huffman
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June (Month) 9th (Day) 1920 (Year)

7. AGE: ... yrs. ... mos. ... ds.
IF LESS than 1 day how many ... hrs. or 10 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ...
(b) General nature of industry business or establishment in which employed (or employer): Infant

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Olsen Huffman

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Katie Pope

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Rothwell MD
(Address) Kendrick Idaho

15.
Filed 6-10 1920 R. F. Pepple
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8th 1920, to June 9th 1920, that I last saw him alive on June 9th 1920, and that death occurred on the date stated above, at 6.50 P M.

The CAUSE OF DEATH* was as follows:
Inability of mother to have uterine contractions pains after head was born. Child large weighing 13 3/4 lbs at birth
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) W. A. Rothwell M. D.
19... (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wild Rose Cemetery — DATE OF BURIAL: June 10 1920

20. UNDERTAKER: Elmer Beckett — ADDRESS: Kendrick Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Juliet Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 60
Primary Registration District No. 2129
File No. 30907
Registered No. 93

1. PLACE OF DEATH
County of Lewis
City of Craigmont
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Laurence Cloris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word.)

6. DATE OF BIRTH: October (Month) 11 (Day) 1918 (Year)

7. AGE: 1 Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clyde E. Cloris

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Christina G. Hoffman

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Cloris
(Address) Craigmont Ida

15. Filed 6/23 1920 R C Dwinell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920, to June 22 1920, that I last saw h[illegible] alive on June 22 1920, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows: accidental Poisoning with Lye.

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R C Dwinell M. D.
6/23 1920 (Address) Craigmont Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F Cemetery — DATE OF BURIAL: 6/23 1920

20. UNDERTAKER: Star Mer Dept Co. — ADDRESS: Craigmont

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2424
(No. ....., ... St.)

File No. 30909
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Deary Kenneth

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Lee Kingglass

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Indian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ? (Month) ? (Day) 1901 (Year)

7. AGE: 19 Yrs. ? Mos. ? ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Through Lee Kingglass
(Address) Kamiah Ida

15. Filed 6/15 1920 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1920, to June 1920, that I last saw her alive on June 13th 1920, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) Over 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) O H Bryan M. D.
6/14 1920 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ind Cem No 2 — DATE OF BURIAL: 6/17 1920

20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. A 5555. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 18
Primary Registration District No. 1016

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30911
Registered No. 221

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm clair Kilgore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July 22 1918
(Month) (Day) (Year)

7. AGE: 1 Yrs. 10 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Garner Kilgore

11. BIRTHPLACE OF FATHER (State or Country): Nebr

12. MAIDEN NAME OF MOTHER: Maybelle cochran

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Garner Kilgore
(Address) Shoshone

15. Filed June 19 1920
J. L. Tuttle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 19th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 13 1920, to June 19th 1920, that I last saw him alive on June 19th 1920, and that death occured on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(a) Bronchopneumonia
.....
(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. N. Bancroft M. D.
19..... (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: McMinnville Ore
DATE OF BURIAL: .....191.....

20. UNDERTAKER: O. J. Brennan
ADDRESS: Shoshone

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

30912

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2016
File No. ~~20911~~
Registered No. 23

1. PLACE OF DEATH.
County of Lincoln
City of Dietrich
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo H Slabaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. unknown
(Month) (Day) (Year)

7. AGE about 45 Yrs. Mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... common Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) U S

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lester Walker
(Address) Shoshone

15. Filed June 21 1920 J L Fuller
Local Registrar

SYMS-YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 20 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 7-45 P. M.

The CAUSE OF DEATH* was as follows:
Thrown from wagon while visiting with friends.
Accidental.
(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) Accident
(Duration) yrs. mos. ds.

(Signed) J L Fuller Coroner M. D.
June 21 1920 (Address) Shoshone Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: McConnell — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: O F Brennan — ADDRESS: Shoshone

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2045
File No. 30213
Registered No. 2

1. PLACE OF DEATH.
County of Lincoln.
City of Near Richfield.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jno T. Judge.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced.
6. DATE OF BIRTH. Aug. (Month) 18. (Day) 1866 (Year)
7. AGE: 54 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): New York.
10. NAME OF FATHER: James Judge.
11. BIRTHPLACE OF FATHER (State or Country): Ireland.
12. MAIDEN NAME OF MOTHER: Mary A Golding.
13. BIRTHPLACE OF MOTHER (State or Country): New Yourk.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. L. Franklin.
(Address) Fruita.
15. Filed 6-5 1920 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

Juba no M.D.

16. DATE OF DEATH June. (Month) 15. (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
No Physician
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
.....19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellevue. DATE OF BURIAL: June 2 - 1920.
20. UNDERTAKER: O. D. Harris. ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SONS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

Primary Registration District No. 2176

File No. 30914

Registered No. 3971

County of

City of (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stanley Mortensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH: March 30 (Month) (Day) 1906 (Year)

7. AGE: 14 yrs. 2 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salem, Idaho

10. NAME OF FATHER: Chris Mortensen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mertie Valentine

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Mae Mortensen

(Address): Salem,

15. Filed 6/14 1920 G. E. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1920, to June 12 1920, that I last saw h[illegible] alive on June 12th 1920 and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Skull Fracture, accidental hit by stick.

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) Cerebral abscess

(Duration) yrs. mos. 1 ds.

(Signed) F. B. Eustace M. D.

6/15 1920 (Address) Lagrande City, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ruckburg — DATE OF BURIAL: 6/15 1920

20. UNDERTAKER: J. H. Young — ADDRESS: Ruckburg

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30917
Registered No. 43

1. PLACE OF DEATH

County of Madison
City of Rexburg,
(No. ..... St.)

Registration District No. 100
Primary Registration District No. 2178

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marjorie Ricks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH: October (Month) 8th (Day) 1912 (Year)

7. AGE: 7 Yrs. 8 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None--child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Ricks

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Vivian Peacock

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Vivian Ricks
(Address) Clawson, Ida.

15. Filed 6-21 1920 G E Esplin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 20 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1920, to June 20 1920, that I last saw her alive on June 20 1920 and that death occurred on the date stated above, at 5:50 M.

The CAUSE OF DEATH* was as follows:

Myelo-Nephritis
Hydrothorax Rt.

(Duration) ..... Yrs. 6 mos. [illegible] ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Rogers M. D.
19 ..... (Address) Rexburg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Clawson, Ida.

19. PLACE OF BURIAL OR REMOVAL: Clawson, Ida.
DATE OF BURIAL: June 21 19 20

20. UNDERTAKER: John Philips
ADDRESS: Rexburg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 700
Primary Registration District No. 2178
File No. 30918
Registered No. 42

1. PLACE OF DEATH
County of Madison
City of Rexburg (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Jensen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 19th (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None-Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg

10. NAME OF FATHER: Enos Jensen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Eunice Peacock

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Eunice Jensen
(Address) Rexburg, Ida.

15. Filed 6/28 1920 G G Estes
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/19 1920 to 6/19 1920
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Stillborn

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) G G Estes M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Idaho
DATE OF BURIAL: June 19 20

20. UNDERTAKER: John Philips
ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Last 5 PM

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 100

County of Madison.

Primary Registration District No. 2178

City of Rexburg (No. ....., ... St.)

File No. 30919

Registered No. 61

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Oliver C Fisher.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH: April (Month) 6 th (Day) 1850 (Year)

7. AGE: 70 yrs. 2 mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Martin Fisher

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Jane Chapman.

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. O. Fisher
(Address) Lorenzo R,F,D, 1

15. Filed 6/19 1920 G. H. Keeler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-18 1920, to 6-18 1920 that I last saw h[illegible] alive on 6/18 1920 and that death occurred on the date stated above, at 5A M.

The CAUSE OF DEATH* was as follows:

old age
no particular disease

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. H. Keeler M. D.

..... 19 .... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Annis	6/21/20 1920
20. UNDERTAKER	ADDRESS
J.R.Young.	Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 100

Primary Registration District No. 2178

File No. 30920

County of Madison

City of

(No. , St.)

Registered No. 60

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	child

6. DATE OF BIRTH: June (Month) 17 (Day) 1920 (Year)

7. AGE: ...Yrs...Mos...ds. IF LESS than 1 day how many 4 hrs. or ...min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Rexburg Madison County, Idaho.

10. NAME OF FATHER: Clifford Hooper

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Cora Lambourn

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clifford Hooper
(Address) Rexburg, Idaho.

15. Filed 6-18 1920 G. Keaple Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17th 1920, to June 17th 1920, that I last saw him alive on June 17th 1920, and that death occurred on the date stated above, at 6:15A M.
The CAUSE OF DEATH* was as follows: Premature Birth

...(Duration) ...Yrs...mos...ds.
Contributory (Secondary)
...(Duration) ...yrs...mos...ds.

(Signed) Lorin A. Rich M. D.
6/17 1920 (Address) Rexburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Marysville	6/19/1920
20. UNDERTAKER	ADDRESS
John Phillips	Rexburg,

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 30921
Registered No. 24

1. PLACE OF DEATH
County of Madison
City of Rexburg
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thelma Beck
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 22 (Day) 1920 (Year)

7. AGE: ——— Yrs. ——— Mos. 1 ds.
IF LESS than 1 day how many 12 hrs. or 15 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ———
(b) General nature of industry, business or establishment in which employed (or employer): ———

9. BIRTHPLACE (State or Country) Rexburg, Idaho

10. NAME OF FATHER William Beck

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Rosa Rottweiler

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lorin L. Rich
(Address) Rexburg, Idaho

15. Filed 6-23 1920 G. G. Gospe
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1920, to June 22 1920, that I last saw her alive on June 22 1920, and that death occurred on the date stated above, at 1:15 P. M.
The CAUSE OF DEATH* was as follows: Premature Birth

(Duration) Yrs. ——— mos. 1 ds.
Contributory (Secondary) .....
(Duration) ——— yrs. ——— mos. ——— ds.
(Signed) Lorin L. Rich M. D.
6/22 1920 (Address) Rexburg, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Idaho. DATE OF BURIAL: 6-22 1920

20. UNDERTAKER: none. ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 30922
Registered No. 5-8

1. PLACE OF DEATH
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margorie Hammer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH
July (Month) 7th (Day) 1919 (Year)

7. AGE
Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None-Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Sugar City, Idaho

10. NAME OF FATHER
Ruthven V. Hammer

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER
Julia A. Robinson

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed 6-15 1920 G. E. Espe
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June 14th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8th 1920, to June 14th 1920, that I last saw her alive on June 14th 1920, and that death occurred on the date stated above, at 8-30 A.M.

The CAUSE OF DEATH* was as follows:
Broncho-Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Pertussis
(Duration) ..... yrs. ..... mos. 21 ds.

(Signed) Parley Nelson M. D.
6-15 1920 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rexburg, Idaho	June 16 1920
20. UNDERTAKER David Young	**ADDRESS** Rexburg, Ida.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 30923
Registered No. 56

1. PLACE OF DEATH.
County of
City of
(No. St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John R. Barber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Married

6. DATE OF BIRTH: Dec 21 1847 (Month) (Day) (Year)

7. AGE: 57 yrs. 6 mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Barber

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Charlotte Kirby

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Lutz
(Address): Rexburg Idaho

15.
Filed 6-19 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 10 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 21 1920 to June 10 1920, that I last saw h[illegible] alive on June 10 1920, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Exaustion

(Duration) — yrs. 3 mos. — ds.
Contributory (Secondary): Hypertrophic cirrhosis of Liver
(Duration) 3 yrs. — mos. — ds.

(Signed) Louis A. Rich M. D.
6/15 1920. (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: 6/15 1920

20. UNDERTAKER: J H Fanning
ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
(No. ..... St.)

File No. 20924
Registered No. 7

1. PLACE OF DEATH

County of Twin Falls
City of Filer

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Gount

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 4 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank A. Gount

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Ella Coleman

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. Alvord Price, M D
(Address) Twin Falls, Idaho

15. Filed 6-7 1920
E E Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 4 1920 to June 7 1920
that I last saw h.e.r. alive on June 5 1920
and that death occurred on the date stated above, at 9.30 A.M.
The CAUSE OF DEATH* was as follows:

Premature baby - 6 mos.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Alvord Price M. D.
19 ..... (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Melrose Ida
DATE OF BURIAL: 6-7 1920

20. UNDERTAKER: W. E. Stoddard
ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 30925
Registered No. 8

1. PLACE OF DEATH
County of Nez Perce
City of Southwick
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Mill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: April (Month) 8 (Day) 1912 (Year)

7. AGE: 8 Yrs. 2 Mos. 2 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER S. B. Mill

11. BIRTHPLACE OF FATHER (State or Country) Wis

12. MAIDEN NAME OF MOTHER Della Elsson

13. BIRTHPLACE OF MOTHER (State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. B. Mill
(Address) Southwick

15. Filed 6-11 1920 E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1920 to 1920
that I last saw her alive on June 9 1920
and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows: Burned
She was burned all over her Body
Accident Clothing Cut fire
by starting a fire in Stove Coal Oil
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. W. Stoneburner M. D.
June 10 1920 (Address) Lenard Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Camerone Cemetery
DATE OF BURIAL: June 11 1920

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 30926
Registered No. 6

1. PLACE OF DEATH
County of Kootenai
City of Chesley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Rupe
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 4 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 10 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Marion J. Rupe

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Vassie Beal

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Alvord Gore, M. D.
(Address) Reubens, Idaho

15. Filed 6-7 1920 E. E. Watts, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/4 1920 to 6/5 1920
that I last saw h.. alive on 6/4 1920
and that death occurred on the date stated above, at 1 A. M.
The CAUSE OF DEATH* was as follows:

Prematurity - 8 mos.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. Alvord Gore, M. D.
6/5 1920 (Address) Reubens, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Reubens | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Sarah Leach | ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

File No. 30927

Registered No. 26

County of Oneida

City of Malad (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellen J Jeffries.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: July (Month) 22 (Day) 1864 (Year)

7. AGE: 65 yrs. 10 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John Fry.

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Sylvia Drade

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Jones
(Address) .....

15. Filed July 5 1920 R O Mauer M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6/ (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1920 to June 20 1920 that I last saw h er alive on 6/20 1920 and that death occurred on the date stated above, at 6:10 P. M.

The CAUSE OF DEATH* was as follows:

Cancer. (lung)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kerns. M. D.

19 ..... (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad — DATE OF BURIAL: June 24 1920

20. UNDERTAKER: J. Guy Benson — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008.
(No. ..... St.)

File No. 30929
Registered No. 29

1. PLACE OF DEATH
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maggie Thayer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June 25 1850 (Month) (Day) (Year)

7. AGE: 69 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich

10. NAME OF FATHER: John Quick

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): No Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Carrie Spindle
(Address) Payette Ida

15. Filed April 2 1920 J. G. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar 31 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 4 1920 to Mar 31 1920
that I last saw h[illegible] alive on Mar 31 1920
and that death occurred on the date stated above, at 1.30 P.M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. G. Woodward M. D.
4/2 1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Apr 2 1920

20. UNDERTAKER: D. T. Blair — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30930
Registered No. 23

1. PLACE OF DEATH
County of Washington
City of Near Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert L. Jimerson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Mar (Month) 9 (Day) 1883 (Year)

7. AGE: 37 Yrs. 1 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Robert L. Jimerson

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Dorothy Perry

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Jimerson
(Address) Payette

15. Filed May 4 1920 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1918, to May 3 1920, that I last saw him alive on April 30 1920, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Pulmonary Hemorrhage
(Duration) 10 minutes yrs. mos. ds.

(Signed) O. H. Avey M. D.
5/3/1920 (Address) Payette, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: 5-4 1920

20. UNDERTAKER: D. H. Adair — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
(No. ..... St.)

File No. 30931
Registered No. 23

1. PLACE OF DEATH
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David H Williams
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Feb (Month) 24 (Day) 1846 (Year)

7. AGE
74 Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) W Virginia

10. NAME OF FATHER Wm Williams

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Leah Higgins

13. BIRTHPLACE OF MOTHER (State or Country) Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H B Williams
(Address) Payette Ida

15. Filed June 8 1920 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1920, to May 20 1920, that I last saw h[illegible] alive on May 20 1920 and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:

Influenza
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary) Pneumonia, Hypostatic
(Duration) yrs. mos. 3 ds.
(Signed) J L McDonald M. D.
19 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Payette Ida | DATE OF BURIAL 5-23 1920

20. UNDERTAKER C N Cain | ADDRESS Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kayette
City of Kayette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

File No. 30932
Registered No. 24
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James N Boyd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Feb (Month) 7 (Day) 1857 (Year)

7. AGE
63 yrs. 4 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Jeweler
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Tenn

10. NAME OF FATHER Martin Boyd

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Martha Pierce

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lee Boyd
(Address) Payette Ida

15.
Filed June 11 1920 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1920, to June 10 1920, that I last saw him alive on June 10 191..., and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Cholecystitis -
probably several years -
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Senility & arteriosclerosis
(Duration) several yrs. ..... mos. ..... ds.
(Signed) Wm T Drysdale M. D.
6-11 1920 (Address) Mrn Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	June 12 191

20. UNDERTAKER	ADDRESS
J Hidair	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 30934
Registered No. 26

1. PLACE OF DEATH.
County of Payette
City of Payette
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stephen Oliver Day

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: November 25 (Month) (Day) 1842 (Year)

7. AGE: 77 yrs. 6 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter & farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Lewis Day

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Childs

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Caroline Day
(Address) Payette Ida

15.
Filed July 7/1920 1920 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 1919, to June 19 1920, that I last saw him alive on June 19 1920, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Chronic Myelitis

Indefinite (Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) O. H. Avery M. D.

7/15/1920 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Ida — DATE OF BURIAL: 6-25 1920

20. UNDERTAKER: D. N. Adair — ADDRESS: Payette Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Payette

City of Payette

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

File No. 30935

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie E Mallon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov 1 1856 (Month) (Day) (Year)

7. AGE: 63 Yrs. 8 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Benjamin Robinson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Liram Huff

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H Alice Allen
(Address) Payette Ida

15. Filed July 7 1920 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1920 to July 6 1920
that I last saw h alive on June 26 1920
and that death occurred on the date stated above, at 3 30 P.M.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. 26 ds.
(Signed) J C Woodward M. D.
July 8 1920 (Address) Payette Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: July 8 1920

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 30936
Registered No. 28

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Estes Hodge
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 18 (Day) 1883 (Year)

7. AGE: 36 Yrs. 6 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: J. H. Rymer

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Smith Knorr

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ben Hodges
(Address) Payette Idaho

15. Filed July 17 1920 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1920, to July 16 1920, that I last saw her alive on July 16 1920, and that death occurred on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:
Ectopic gestation

(Duration) About one mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.
7/16/1920 (Address) Payette, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: July 18 1920

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5—20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai — Registration District No. 5
City of New Plymouth — Primary Registration District No. 2009
(No. ....., ... St.)
File No. 30937
Registered No. 7
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Colman S French

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Nov 27 1847 (Month) (Day) (Year)

7. AGE: 72 yrs. 6 mos. 8 ds. — IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Micah French

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Eunidice E Parker

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed P French
(Address) New Plymouth Ida

15.
Filed June 6 1920 Wm T. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: ~~May~~ June 5 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~May~~ June 3 1920, to ~~May~~ June 5th 1920, that I last saw him alive on June 4 1920, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Prostatic Hypertrophy

(Duration) many yrs. mos. ds.
Contributory (Secondary) Pyelo Nephritis
(Duration) probably 10 or 12 yrs. mos. ds.

(Signed) Wm T Drysdale M. D.
6-6 1920 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Ida — DATE OF BURIAL: June 7 1920

20. UNDERTAKER: N Adair — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2012
File No. 30938
Registered No. 151

1. PLACE OF DEATH.
County of Power
City of Lower Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Not named

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Single)

6. DATE OF BIRTH: 5 (Month) — 28 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm Albert Nowding

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Martha Bethke

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Albert Nowding
(Address) Lower Falls Ida

15. Filed 6 — 12 1920 R. F. Motts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 6 (Month) — 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920, to June 1 1920 that I last saw h[illegible] alive on " 1 1920 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Congestive Intestinal Obstruction

(Duration) ..... yrs. ..... mos. 4½ ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. F. Motts M. D.
6/2 1920 (Address) Lower Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lower Falls	6/2 1920
20. UNDERTAKER	ADDRESS
Arthur Davis	Lower Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

30939 State of Idaho

CERTIFICATE OF DEATH

BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21-
Primary Registration District No. 2072
File No. 2
Registered No. 162

1. PLACE OF DEATH
County of Power
City of American Falls (No. Bethany Deaconess Hos.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William E. Hatley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word): Married

6. DATE OF BIRTH. July (Month) 14 (Day) 1897 (Year)

7. AGE: 23 Yrs. 9 Mos. 18 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hammer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dayton Washington

10. NAME OF FATHER: Elijah Hatley

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Hannah Stanfield

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hannah Hatley
(Address) American Falls Ida

15. Filed June 3 1920 R. F. Nott Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31st 1920 to June 2nd 1920 that I last saw him alive on June 2nd 1920 and that death occurred on the date stated above, at 2-10 P. M.

The CAUSE OF DEATH* was as follows:
Influenza followed by Pneumonia
Acute 3
(Duration) Yrs. mos. ds.
Contributory (Secondary) General Peritonitis
(Duration) Yrs. mos. ds.
(Signed) Richard F. Nott M. D.
6/3 1920 (Address) American Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 weeks yrs. mos. days. In the State Hospital yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Arbon Valley Ida

19. PLACE OF BURIAL OR REMOVAL: Dayton Washington — DATE OF BURIAL: June 5 1920

20. UNDERTAKER: H. L. McHard — ADDRESS: Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30940

Registered No. .....

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. .....

Primary Registration District No. .....

(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Glenn Robert Samson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	single

6. DATE OF BIRTH. April (Month) 21 (Day) 1920 (Year)

7. AGE 0 Yrs. 0 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm E Samson

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Grace Strike

13. BIRTHPLACE OF MOTHER (State or Country) Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Grace Samson
(Address) St Regis Mont.

15. Filed May 4 1920 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH May (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4/30/20 191.., to 5/4/20 191.., that I last saw h.. alive on 5/4/20 191.., and that death occured on the date stated above, at 5 M.

The CAUSE OF DEATH* was as follows:

Tuberculosis -

(Duration) Yrs. 2 mos. 13 ds.

Contributory (Secondary) Pulmonary hemorrhage -

(Duration 2 yrs. 4 mos. 13 ds.

(Signed) Forrest C. Jones M. D.

MAY 5 1920 (Address) Wallace Idaho -

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 5 days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence St Regis Mont.

19. PLACE OF BURIAL OR REMOVAL Wallace Id — DATE OF BURIAL 5/5 1920

20. UNDERTAKER R Crowell — ADDRESS Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30942

Registered No. 30

Registration District No. .....

Primary Registration District No. .....

(No. Providence Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

2. FULL NAME Felix Jovanovich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 35 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business, or establishment in which employed (or employer): Lead Silver Mine

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Dolan

(Address) Wallace, Idaho

15. Filed June 4th 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/20 1920, to 5/29/20 191..., that I last saw h. m. alive on 5/28/20 191..., and that death occured on the date stated above, at 9a M.

The CAUSE OF DEATH* was as follows:

Laceration Neck, severed trachea, severed pt jugular, Suicidal

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... Yrs. ..... mos. ..... ds.

6/4 1920 (Signed) James R Bean M. D.

(Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: 6/3rd 1920

20. UNDERTAKER: B. G. Worstell — ADDRESS: Wallace Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS-DARK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 7200
File No. 30943
Registered No. 46

1. PLACE OF DEATH.
County of Shoshone
City of Murray
(No. Residence St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Cochrane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 75 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Thomas Cochrane

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Jean Proctor

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Estelle Hamerlyn
(Address) Seattle Wash 6200 4th ave N.W.

15. Filed June 3 1920 H. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May 31 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1920, to May 26 1920
that I last saw her alive on May 26 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Labor Pneumonia

(Duration) ..... yrs. ..... mos. 8 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. Mowry M. D.
June 19 20 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: June 4 1920

20. UNDERTAKER: Harry Thompson ADDRESS: Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2250
File No. 30944
Registered No. 47

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Burke Idaho St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Lawrence Chatham
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 18 (Day) 1915 (Year)

7. AGE: 4 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Chas Fred Chat ham

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Margaret Murphy

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M L Mahoney
(Address) Burke Ida

15. Filed June 17 1920 H C Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1920, to June 12 1920, that I last saw h.... alive on June 12 1920 and that death occured on the date stated above, at 11P M.

The CAUSE OF DEATH* was as follows:
Diphtheria
.....(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Carditis failure
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
19.. (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thompson Mont
DATE OF BURIAL: June 15 1920
20. UNDERTAKER: B G Worstell
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PRS. & STRS. 24653

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30945
Registered No. 48

1. PLACE OF DEATH. Registration District No. 12
Primary Registration District No. 27
County of Shoshone
City of Mullan (No. Mullan Idaho St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Andy Ward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 40 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Quartz Mining
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F W Rolfs MD
(Address) Mullan Ida

15. Filed June 15 1920 H. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1920, to June 14 1920
that I last saw him alive on June 11 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of the Lungs

(Duration) 2 about yrs. ..... mos. ..... ds.
Contributory (Secondary) Insobriety
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F W Rolfs M. D.
June 14 1920 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE ~~OF BURIAL~~ OR REMOVAL: To Wallace
DATE OF BURIAL: June 15 1920

20. UNDERTAKER: Worstell Undtak. Co
ADDRESS: Wallace Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 122

Primary Registration District No. 2200

File No. 30946

County of Shoshone

City of Near Wallace Ida (No. Tamarack Mine St.)

Registered No. 47

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur F. Pittelkau

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	white	Single

6. DATE OF BIRTH: February (Month) 18th (Day) 1898 (Year)

7. AGE: 22 yrs. 4 mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer): Attending School

9. BIRTHPLACE (State or Country): Carrolls, Cowlitz County, Washington

10. NAME OF FATHER: August J. Pittelkau

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elizabeth Leslie

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George B. Pittelkau
(Address) 444 Whitman Ave Seattle Washington

15. Filed June 27 1920 H. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 26th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

accident.
Fell down Timber Slide
in Tamarack & Custer Mine

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. W. Mauer Justice of the Peace
Wallace Precinct Kotz Deputy Coroner
June 28 1920 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence Seattle Wash Single

19. PLACE OF BURIAL OR REMOVAL: Seattle Wash — DATE OF BURIAL: June 29 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

I. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19780

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30947
Registered No. 30

1. PLACE OF DEATH.
Registration District No. 122
County of Shoshone
Primary Registration District No. 2200
City of Sunset
(No. Residence St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Stringam

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	Widowed

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
69 yrs. — mos. — ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Teamster
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Illinois

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER
(State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ben. Stringam
(Address) Sunset Idaho

15.
Filed June 27 1920 H. C. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1920 to June 27 1920
that I last saw him alive on June 26 1920
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows: Cerebral Apoplexy

(Duration) yrs. mos. 3 ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) H. C. Mowery M.D.
6/30 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Sunset Idaho

19. PLACE OF BURIAL OR REMOVAL Wallace Ida | DATE OF BURIAL July 2nd 1920

20. UNDERTAKER Harry Thompson | ADDRESS Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30948

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 1433
Primary Registration District No. 7701
File No. 30
County of Shoshone
City of Kellogg (No. ..., St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Arnold Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	S

6. DATE OF BIRTH: Apr (Month) 9 (Day) 1920 (Year)

7. AGE: ... yrs. ... mos. 3 ds.
IF LESS than 1 day how many ... hrs. or ... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kellogg Idaho

10. NAME OF FATHER: Guy Stewart

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Guy D Steward
(Address) Kellogg, Idaho

15. Filed 6/29 1920 Geo L Kesler Local Registrar

MEDICAL CERTIFICATE OF DEATH.

Mason

16. DATE OF DEATH: Apr (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 9 1920, to Apr 12 1920, that I last saw him alive on Apr 12 1920 and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Hemorrhage of bowels

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. R. Mason M. D.
Apr 20 1920 (Address) Kellogg, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Apr 13, 1920

20. UNDERTAKER: W. C. Trumbic — ADDRESS: Kellogg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30949

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 173

County of Shoshone

Primary Registration District No. 7701

File No. 29

City of Kellogg (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Theodore Walter Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH: Feb (Month) 23 (Day) 1920 (Year)

7. AGE: 0 yrs. 1 mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. S. Brown

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ida L. Ellis

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W S Brown

(Address) 224 Cameron Ave Kellogg, Idaho

15. Filed 6/27 1920 Jos. Kesler Local Registrar

MEDICAL CERTIFICATE OF DEATH

Lindsay

16. DATE OF DEATH: March (Month) 24, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 23, 1920 to March 24 1920, that I last saw him alive on March 24 1920, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Prematurity

(Duration) 0 yrs. ..... mos. ..... ds.

(Signed) R C Lindsay M. D.

4/3 1920 (Address) Kellogg Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Mch 25, 1920

20. UNDERTAKER: M. C. Thornhill — ADDRESS: Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

6VMS - YORK CO., PTRS. & BORS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

30950

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 123

Primary Registration District No. 2701

File No. 28

County of Shoshone

City of Kingston (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Herbert Lahte

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: June (Month) 7 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work at home
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Evavills.

10. NAME OF FATHER Matt Lahte.

11. BIRTHPLACE OF FATHER (State or Country) Finnland

12. MAIDEN NAME OF MOTHER Lillian Aro

13. BIRTHPLACE OF MOTHER (State or Country) Montana.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Matt Lahte
(Address) Evavills

15. Filed 6/28 1920 W. Geo. D. Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Granulation,
.....
.....
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo P Shepherd M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kingston | DATE OF BURIAL: June 21 1920

20. UNDERTAKER: Jos Underwaters | ADDRESS: Evavills

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30951

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 2176
File No. 23
Registered No. 2000

1. PLACE OF DEATH
County of Teton
City of Tetonia
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melissa Ann Shaw
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 23 (Day) 1859 (Year)

7. AGE: 61 Yrs. 8 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Alonzo T. Atwood

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Mary L Barber

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl H. Shaw
(Address) Driggs

15. Filed June 29 1920 Martha Marker
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920 to June 28 1920
that I last saw h.. alive on June 27 1920
and that death occurred on the date stated above, at 1.35 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis,
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas J Martin M. D.
June 29 1920. (Address) Driggs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tetonia Ida
DATE OF BURIAL: June 30 1920

20. UNDERTAKER —
ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

30953

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Kimberly

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36

Primary Registration District No.

(No. , St.)

File No.

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Levon Roy Wood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	W	S (Write the word.)

6. DATE OF BIRTH

Febr. (Month) 5 (Day) 1920 (Year)

7. AGE

Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE

(State or Country) Idaho

10. NAME OF FATHER

Roy Wood

11. BIRTHPLACE OF FATHER

(State or Country) Idaho

12. MAIDEN NAME OF MOTHER

Stella Sudweeks

13. BIRTHPLACE OF MOTHER

(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Roy Wood

(Address) Kimberly Ida

15.

Filed June 12 1920

J. M. Davis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

June (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920 to June 11 1920 that I last saw him alive on June 11 1920, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-enteritis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Davis M. D.

6/12 1920 (Address) Kimberly, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: June 12 1920

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

30954 Dr Alexander

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of " "

(No. ; St.)

Registration District No. 37

Primary Registration District No. 1082

File No.

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Ruth Watson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 7 (Day) 20 (Year)

7. AGE: Yrs. Mos. 28 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: Clare B. Watson

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Vida Yowell

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vida Watson.

(Address) Twin Falls, Ida

15. Filed June 7 1920 John H. Caughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 5103

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3rd 1920, to June 4th 1920 that I last saw h.er alive on June 4th 1920 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Bilateral

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. L. Alexander M. D.

6/5 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 6/4 1920

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

Sawyer.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1885
File No. 30955
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of ... "
If death occurs away from usual residence, give facts called for under special information.
(No. ..., ... St.)

2. FULL NAME Dorothy Eunice Stanley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 10 (Day) 20 (Year)

7. AGE: ... Yrs. ... Mos. ... ds.
IF LESS than 1 day how many 36 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls

10. NAME OF FATHER: Wm H. Stanley.

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Daisy E. Snodgrass

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm H Stanley
(Address) Twin Falls Ida.

15. Filed June 12 1920 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1920, to June 11 1920, that I last saw h/er alive on June 11 1920, and that death occurred on the date stated above, at 7:30 p.m.
The CAUSE OF DEATH* was as follows:
Incomplete abdominal Pregnancy Ovarian
(Duration) ... Yrs. ... mos. 36 hrs ds.
Contributory (Secondary) Breech presentation
(Duration) ... yrs. ... mos. 36 hrs. ds.
(Signed) H H Sawyer M. D.
6/12 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 6/12 1920

20. UNDERTAKER: [illegible] — ADDRESS: Twin Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

Dr

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30956

Registered No.

Registration District No. 37

Primary Registration District No. 1085

1. PLACE OF DEATH

County of Twin Falls

City of " "

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sam Watson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Don't Know. (Write the word.)

6. DATE OF BIRTH: Don't Know (Month) (Day) 1 (Year)

7. AGE: About 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Don't Know

(b) General nature of industry, business or establishment in which employed (or employer): " "

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) County Hospital Records

(Address) Twin Falls Ida

15. Filed June 28 1920 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920 to June 17 1920 that I last saw h[illegible] alive on June 17 1920 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of both Lungs

Don't Know

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Exhaustion

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. E. M. McGinnis M. D.

6/18 1920 (Address) 415 Folks E. Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

16. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida

DATE OF BURIAL: 6/18 1920

20. UNDERTAKER: J. A. Grossman

ADDRESS: Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30957
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Priscilla Swanson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 20 (Day) 1878 (Year)

7. AGE: 42 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): Ill

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: J G Ayers

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Priscilla Dorsey

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C C Munson
(Address) Twin Falls Idaho

15. Filed July 10 1920 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 1920, to July 7 1920, that I last saw her alive on July 7 1920, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Carcinoma

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. R. Scott M. D.
7-9 1920 (Address) Twin Falls-Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho
DATE OF BURIAL: 7-11 1920

20. UNDERTAKER: J E Devitt
ADDRESS: Twin Falls.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30958
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha R. Drake
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: June (Month) 28 (Day) 1868 (Year)

7. AGE: 52 Yrs. — Mos. 4 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Leonard G. Rice

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Margrett Brockenbrough

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Drake
(Address) Victor Ida.

15. Filed July 9 1920 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1920, to July 2 1920, that I last saw h.er alive on July 2 1920, and that death occurred on the date stated above, at 11th A.M.

The CAUSE OF DEATH* was as follows:
Complete Hysterectomy
Causing Acute dilatation
of Stomach.
(Duration) Yrs. mos. 7 ds.
Contributory (Secondary): Anemia - Accidental
(Duration) yrs. mos. ds.

(Signed) John R. Morgan, M. D.
July 2 1920 (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Victor Ida. | DATE OF BURIAL ... 19...
20. UNDERTAKER: J. J. Jacquemar | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30950
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Ehlers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec. 31 1917 (Month) (Day) (Year)

7. AGE: 2 Yrs. 6 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer): Rancher

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Emil Ehlers

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Marie Mathiesen

13. BIRTHPLACE OF MOTHER (State or Country): Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwin G. Ehlers
(Address) Twin Falls Ida

15. Filed July 9 1920
John F Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 4th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1920, to July 4 1920, that I last saw h[illegible] alive on July 3 1920 and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) Yrs. mos. 20 ds.
Contributory (Secondary): Mitral Insufficiency
(Duration) yrs. 2 mos. ds.

(Signed) H. J. Lester M. D.
July 5 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: July 5 1920
20. UNDERTAKER: [illegible] Twin Falls
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr Coughlin

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 30960
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bob William Z. Iron Jr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 6 (Day) 920 (Year)

7. AGE: X Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: Wm. Z. Iron

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Lula P. Goldhawk.

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Z Iron.
(Address) Twin Falls

15. Filed July 8 1920 John F Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th 1920, to July 7 1920
that I last saw h. alive on July 7 1920
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows: Protracted Labor

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F Coughlin M. D.
7-8 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 7/8 1920

20. UNDERTAKER: P. J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Alex

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30961
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Jane Wallington
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Nov. (Month) 17 (Day) 1 (Year)

7. AGE: 53 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: T. J. West.

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Francis Carter

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed. W. Wallington
(Address)

15. Filed July 9 1920 John E. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feby 1 — 1920 to July 7 1920
that I last saw h[illegible] alive on July 7 1920
and that death occurred on the date stated above, at 1:45 P.M.
The CAUSE OF DEATH* was as follows:

Hemorrhage Intestinal.

(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) Carcinoma Intestinal
(Duration) 1 yrs. mos. ds.

(Signed) D. K. Alexander M. D.
7/8 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: July 8 1920
20. UNDERTAKER: T. J. Grossman
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Form V. S. No. 5 ~~20M.1-16-12~~

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30963
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1685
(No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard De Norton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
June 1 1919
(Month) (Day) (Year)

7. AGE
1 yrs. mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work rancher
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Clarence E Norton

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Mae West.

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence E. Norton
(Address) Kimberly Idaho

15.
Filed 191
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 28 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1920, to June 28 1920, that I last saw him alive on June 28 1920, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from anterior fontanelle
Accidental penetrating wound
(Duration) 0 yrs. 0 mos. 1 ds.

Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) E. M. VanCott M. D.
6-30 1920 (Address) Twin Falls, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls — DATE OF BURIAL June 30 1920

20. UNDERTAKER C. J. Foreman — ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30964
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Fellon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: ... 1 (Month) (Day) (Year)

7. AGE: ... Yrs. Mos. 1 ds. IF LESS than 1 day how many ... hrs. or ... min.? 4h

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo Fellon

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Etha Spencer

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Fellon
(Address)

15. Filed June 24 1920 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 - 23 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/23 19... to 6/23 19... that I last saw h.er alive on 6/23 1920 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Premature — 6½ mo.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) E. D. Weaver M. D.
19... (Address) Twin Falls,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 6 - 24 1920

20. UNDERTAKER: E E Court — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 30965
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Teresa Jameson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept 12 1 (Month) (Day) (Year)

7. AGE: 99 Yrs. 9 Mos. 17 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lawrence

10. NAME OF FATHER: Evert welsh

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Allie Ryan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas A Jameson
(Address) 175 Gurney ave

15. Filed June 29 1920 John F Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 – 29 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1920, to June 29 1920 that I last saw h.e alive on June 29 1920, and that death occurred on the date stated above, at 6 AM

The CAUSE OF DEATH* was as follows:
Arteriosclerosis and
Cerebral Hemorrhage
Acute
(Duration) Yrs. mos. ds.
Contributory (Secondary) Arteriosclerosis
Hemaplegia (Duration) about one year yrs. mos. ds.
(Signed) Drs Wyatt & Brown D.C. M. D.
6/29 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: 6-30 1920

20. UNDERTAKER: L E Stewart | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30967

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
Registration District No. 38
County of Twin Falls
Primary Registration District No. 2086
City of Filer. (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME C. M. Cady

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH
..... 1 .....
(Month) (Day) (Year)

7. AGE
..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer.

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER No information

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed June 15 1920 A. A. Newberry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
..... 191...
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1920 to June 15 1920
that I last saw h.im alive on June 15 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Crebral Hemarage.

(Duration) ..... yrs. 4 hours ds.

Contributory (Secondary) .....
(Duration) 10 yrs. H[illegible] ds.
(Signed) Frank A. Dwight M. D.
19.... (Address) Filer.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Stewart Iowa. DATE OF BURIAL ..... 191...

20. UNDERTAKER L. E. Drake. ADDRESS Filer.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30968
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 9886
(No. ..... St.)

2. FULL NAME S. D. McBride

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 20 (Day) 1858 (Year)

7. AGE 61 Yrs. 11 Mos. ..... ds. IF LESS THAN 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER William McBride

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. McBride
(Address) Filer

15. Filed June 11 1920 A. A. Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920 to June 8 1920 that I last saw him alive on June 8 1920 and that death occurred on the date stated above, at 9:25 P.M.

The CAUSE OF DEATH* was as follows:

Shock
(Duration) ..... Yrs. ..... mos. 6 Hours ds.
Contributory (Secondary) Gastric Carcinoma
(Duration) 10 Yrs. ..... mos. ..... ds.

(Signed) C. A. Dwight M. D.
June 11 1920. (Address) Filer, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos. 13 days. In the State....yrs....mos....days
County Hospital Twin Falls, Ida.
Where was disease contracted if not at place of death? Not Known.
Former or usual residence Filer, Ida.

19. PLACE OF BURIAL OR REMOVAL Sacred Heart Cemetery — DATE OF BURIAL June 11 1920.
UNDERTAKER — ADDRESS

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30969
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Twin Falls
City of Twin Falls. (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086

2. FULL NAME Eli Stone

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married.

6. DATE OF BIRTH
Nov. 13 1 67
(Month) (Day) (Year)

7. AGE
62 yrs. 4 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Indiana.

10. NAME OF FATHER James E. Stone

11. BIRTHPLACE OF FATHER (State or Country) Indiana.

12. MAIDEN NAME OF MOTHER Martha Anders

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Forest Stone
(Address) Filer. Idaho.

15.
Filed June 11 1920 A.A. Newberry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 10 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 27 1920 to June 9 1920
that I last saw him alive on June 9 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Exophthative goitre
(operation)
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. W. Wilson M. D.
June 10 1920 (Address) Twin Falls. Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Howard, Kans. DATE OF BURIAL: ..... 191..

20. UNDERTAKER: F. E. Drake ADDRESS: Filer.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30976
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Burley
Registration District No. 39
Primary Registration District No. 7017
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matthew Evan Jones

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: January (Month) 20th (Day) 1904 (Year)
7. AGE: 16 yrs. 5 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: Joseph T. Jones
11. BIRTHPLACE OF FATHER (State or Country): Wales
12. MAIDEN NAME OF MOTHER: Mary Ann Henderson
13. BIRTHPLACE OF MOTHER (State or Country): Scotland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Joseph Jones
(Address) H. H. Warner Ranch, Twin Falls Co.
15.
Filed 7-1 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 30th (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 10-5 1919, to 6-30 1920
that I last saw him alive on 6-30 1920
and that death occurred on the date stated above, at 11:00 A. M.
The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(Duration) yrs. 9 mos. ds.
Contributory (Secondary) Mitral Regurgitation
(Duration) yrs. 7 mos. ds.
(Signed) George D. Randall M. D.
7-1 1920 (Address) Burley - Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Cemetery — DATE OF BURIAL: July 3rd 1920
20. UNDERTAKER: W. B. Evans — ADDRESS: Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 30971
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Lathrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Feb (Month) 16 (Day) 1 917 (Year)

7. AGE: 3 Yrs. 3 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: A. E. Lathrom

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Lady Florence Riley

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Lathrom
(Address)

15. Filed 6-1 1920 J. F. Merrifield Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1920, to May 31 1920, that I last saw her alive on May 31 1920, and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Uremia.

(Duration) 3 Yrs. 3 mos. 16 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) G. A. Marsh M. D.
1920 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery	June 2 1920
20. UNDERTAKER	ADDRESS
Howell & Rugg	Buhl Ida

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 15

County of Valley Primary Registration District No.

File No. 30972

City of (No., St.)

Registered No. 62

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Olsen

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Wht.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: 12 (Month) — 21 (Day) 1893 (Year)

7. AGE: 27 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colo

10. NAME OF FATHER: C H Olsen

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: ——

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): G E Morgle
(Address): Cascade

15.
Filed 7—6 1920 Mary R McDonald Dept Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-19 1920, to 6-20 1920 that I last saw h in alive on 6-19 1920, and that death occurred on the date stated above, at 1 a M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation of Brain
(Duration) yrs. mos. 2 ds.
Contributory (Secondary) Influenza
(Duration) yrs. mos. ds.
(Signed) G E Morgle M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade | DATE OF BURIAL: 6-22 1920

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

30973

Registration District No. 86
Primary Registration District No. 2112
File No.
Registered No. 31

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Ray.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov 6th 1 (Month) (Day) (Year)

7. AGE: 60 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Syrena Lacky

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leonard A. Ray
(Address) Weiser Idaho

15.
Filed June 21 1920 W. R. Hamilton Local Registrar
M. L. H.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 3 1920, to May 3 1920, that I last saw h[illegible] alive on May 3 1920, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Consumption
La Grippe

(Duration) 2 Yrs. 0 mos. 0 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. D. Lovan M. D.

5/4 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 5/4 1920

20. UNDERTAKER: Hawthorn & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 30974
Registered No. 32

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leora Marie Cowper
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 6 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Sydney Cowper

11. BIRTHPLACE OF FATHER (State or Country): Ore

12. MAIDEN NAME OF MOTHER: Hattie Lloyd

13. BIRTHPLACE OF MOTHER (State or Country): Kas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sydney E. Cowper
(Address) Weiser Idaho.

15. Filed June 21 1920 — W. R. Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1920, to May 17 1920, that I last saw h.er alive on May 17 1920, and that death occurred on the date stated above, at 4:40 P.M.
The CAUSE OF DEATH* was as follows:
Pemphigus
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. B. Smyth M. D.
5/18 1920 (Address) Weiser, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Provo Utah
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Northam McCann
ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30975
Registered No. 33

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16
Primary Registration District No. 1010

2. FULL NAME Law Draper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 22 (Day) 1881 (Year)

7. AGE: 38 Yrs. 11 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ino.

10. NAME OF FATHER: J B Johnson

11. BIRTHPLACE OF FATHER (State or Country): Ino

12. MAIDEN NAME OF MOTHER: Nancy Cannon

13. BIRTHPLACE OF MOTHER (State or Country): Ino

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) May Nolan
(Address) Weiser Idaho

15. Filed June 21 1920
W. R. Hamilton
Local Registrar
M. L. H

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Murdered. Shot by Sister who later committed Suicide
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. L. Northam Coroner M. D.
5/15 1920 (Address) Weiser. Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery | DATE OF BURIAL: 5/18 1920
20. UNDERTAKER: Northam McCain | ADDRESS: Weiser Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30976
Registered No. 34

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
Registration District No. 86
Primary Registration District No. 1010

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Della Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept (Month) 15 (Day) 1876 (Year)

7. AGE: 43 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: J B Johnson

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Nancy Cornier

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) May Nolan
(Address) Weiser Idaho.

15. Filed June 21 1920 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Suicide by Shooting

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. L. Northam Coroner M. D.
5/15 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fillerest Cemetry — DATE OF BURIAL: 5/18 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Conant

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86

Primary Registration District No. 2112

(No. ..... St.)

File No. 30977

Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W E Lytle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1863 (Year)

7. AGE: 57 Yrs. 2 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: James Willis Lytle

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. F. Lytle

(Address)

15. Filed June 21 19 20

W. P. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/8/20 19..., to 5/12/20. 19...
that I last saw h... alive on 5/12/20. 19...,
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Intestinal paresis
(Post partum)

(Duration) ... Yrs. ... mos. 2 ds.

Contributory (Secondary) Suppurative appendicitis

(Duration) ... yrs. ... mos. 1 ds.

(Signed) C C Conant M. D.

5/12 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerton Cemetery — DATE OF BURIAL: 5-13 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19. Finney

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 30978
Registered No. 36

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emery Eugene Irwin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 27 (Day) 1915 (Year)

7. AGE: 4 Yrs. 4 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm H. Irwin

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Lavina True

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. H. Irwin
(Address) .....

15. Filed June 21 1920 — W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 5 (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 4-28 1920 to 5 15 1920 that I last saw him alive on 5 15 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis.

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest O. Finney M. D.

5/14 1920 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerest Cemetery — DATE OF BURIAL: 5-17 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 56
Primary Registration District No. 2112
File No. 3093
Registered No. 37

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John M. Harris
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Wht	Married

6. DATE OF BIRTH: Nov. (Month) 4 (Day) 1864 (Year)

7. AGE: 56 Yrs. — Mos. 26 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Noah W Harris

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mary Poter

13. BIRTHPLACE OF MOTHER (State or Country): Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. W. Harris
(Address) Weiser. Idaho

15. Filed June 21 1920
W. R. Hamilton
Local Registrar
M. D.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Found dead in bed had been troubled with heart for years.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. L. Northam Coroner
5/1 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Monroe Creek Cemetery — DATE OF BURIAL: May 2 1920

20. UNDERTAKER: Northam & McEuen — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 30980
Registered No. 38

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily P. Nelson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 17 (Day) 1872 (Year)

7. AGE: 48 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: N. P. Nelson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: ——

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. J. Nelson
(Address) Weiser Idaho

15. Filed June 22 1920 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1920 to May 27 1920 that I last saw her alive on May 26 1920 and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Interstitial nephritis
(Duration) 5 Yrs. — mos. — ds.
Contributory (Secondary) Cardiac insufficiency
1 yr (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Wm. Marshall M. D.
May 30 1920 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 5-30 1920
20. UNDERTAKER: Northrop McCann — ADDRESS: Weiser Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 30982
Registered No. 40

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Peterson Mueller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 18 (Day) 1884 (Year)

7. AGE: 36 Yrs. / Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Andrew Peterson

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Miranda Lockley

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willis Peterson
(Address) Weiser Idaho, Rt #1.

15. Filed June 22 1920 W. R. Hamilton Local Registrar
W. L. H.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 8 1920 to May 18 1920
that I last saw her alive on May 18 1920
and that death occurred on the date stated above, at 2:15 P.M.
The CAUSE OF DEATH* was as follows:

Acute Nephritis
Uraemia
Coma

(Duration) ..... Yrs. / mos. ..... ds.

Contributory (Secondary)
May 9 20 (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Marshall M. D.
5/15 1920 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery
DATE OF BURIAL: 5-18 1920

20. UNDERTAKER: Northrup McCann
ADDRESS: Weiser Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Undertrained

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 30983
Registered No. 27

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Lock
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ (Widowed)

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1857 (Year)

7. AGE: 62 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jeptha M York
(Address) Rupert Idaho

15.
Filed June 22 1920 — W. P. Hamilton, Local Registrar
M. L. H.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1917, to May 29 1920, that I last saw h~~e~~ alive on May 29 1920, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Mitral regurgitation
(Duration) many Yrs. ..... mos. ..... ds.
Contributory (Secondary) Paralysis
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) G. M. Valentine M. D.
6/1 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 6-1 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Weiser

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 30985
Registered No. 43

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugene E Fairhurst

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Aug (Month) 29. (Day) 1911 (Year)

7. AGE: — Yrs. 9 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Fred G. Fairhurst

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Ada Hendricks

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred G. Fairhurst
(Address) Weiser

15. Filed June 22 1920 W. R. Hamilton Local Registrar
M. L. H.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920, to June 1 1920
that I last saw him alive on June 1 1920,
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Scarlet fever

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W Hutchinson M. D.
6/22 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery
DATE OF BURIAL: 6/2 1920

20. UNDERTAKER: Northam & McBee
ADDRESS: Weiser Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86

Primary Registration District No. 1010

(No. ..... St.)

File No. 30986

Registered No. 44

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maxine Nichols Glenn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Mar 1 1920 (Month) (Day) (Year)

7. AGE: — Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: D. G. Glenn

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mame Nichols

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. D. G. Glenn

(Address) Weiser, Idaho

15.

Filed June 22 1920

W. R. Hamilton
Local Registrar
M. L. H.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: March 24th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 23 1920, to Mar 24 1920 that I last saw h[er] alive on Mar 24 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Acute indigestion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Alimentary intoxication

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) C. O. Dunaway M. D.

May 19 1920 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bullocrest Cemetery — DATE OF BURIAL: 4/25 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86

Primary Registration District No. 1010

(No. ..... St.)

File No. 30987

Registered No. 45

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hattie Cooper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 14 (Day) 1846 (Year)

7. AGE: 73 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: W. A. Lloyd

11. BIRTHPLACE OF FATHER (State or Country): Va

12. MAIDEN NAME OF MOTHER: Luella Dennis

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Ned Hamilton

(Address) Weiser Idaho

15. Filed June 22 1920 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1920 to May 11 1920 that I last saw h. alive on May 11 1920. and that death occurred on the date stated above, at 2:15 A.M.

The CAUSE OF DEATH* was as follows: Post operative Intestinal Paresis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cesarean Section

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. B. Shirley M. D.

5/12 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Provo. Utah — DATE OF BURIAL: 5/12 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 30988
Registered No. [redacted]

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Stone
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	married

6. DATE OF BIRTH
Nov (Month) 3 (Day) 1885 (Year)

7. AGE
34 Yrs. 7 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Wm. Stone

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Lucy Hurt

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. G. Stone
(Address) Athena Ore.

15. Filed June 23 1920 W. R. Hamilton Local Registrar M. L. N.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June 15th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10th 1920, to June 15th 1920, that I last saw h. alive on June 15th 1920, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Thrombosis (Post operative

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Appendicitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

6/16 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Athena. Oregon	19

20. UNDERTAKER	ADDRESS
Hoffman & McCann	Weiser, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1610
File No. 30989
Registered No. 18

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander McLeod
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: — (Month) — (Day) 1 (Year)

7. AGE: About 31 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Norman McLeod

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hugh H Forbes
(Address) Emmett Ida

15. Filed June 22 1920 M. P. Hamilton Local Registrar
M. P. H

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 28th 1920, to Apr 29 1920, that I last saw h— alive on Apr 29 1920, and that death occurred on the date stated above, at 1:20 P.M.

The CAUSE OF DEATH* was as follows:
Intestinal Obstruction

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C O Swanson M. D.
4/29 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida
DATE OF BURIAL: 5-1 1920

20. UNDERTAKER: Northam McCaw
ADDRESS: Weiser

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 30990
Registered No. 48

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ephriam Larsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 26. (Day) 1855 (Year)

7. AGE: 34 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James Larsen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Annie Larsen

13. BIRTHPLACE OF MOTHER (State or Country): Sweeden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Vivian K Larsen
(Address) Weiser, Idaho.

15. Filed June 24 1920 W. R. Hamilton Local Registrar
M. L. H.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6 21 1920 to 6 22 1920 that I last saw h. alive on 6 22 1920 and that death occurred on the date stated above, at 8 0 M.

The CAUSE OF DEATH* was as follows:

Encephalitis following accidental blow on head.

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Emmet O. Turner M. D.

6/24 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Tyrone Utah | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Northam & McCann | ADDRESS Weiser

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 1010
File No. 30991
Registered No. 489

2. FULL NAME Vesser Dishon
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wt
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: June (Month) 11 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 1 hour ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E J Dishon

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mattie Crow

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E J Dishon
(Address): Weiser, Idaho

15. Filed June 23 1920 W. A. Hamilton Local Registrar
M. L. H.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1920, to ..... 19....., that I last saw h[illegible] alive on June 11 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature birth
1 hour
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W Hatchison M. D.
6/17 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL, REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 6/12 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

• WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2112
(No. ..... St.)

File No. 30999
Registered No. 49

1. **PLACE OF DEATH**

County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Roy E Kelly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. **DATE OF BIRTH** June 22 1917
(Month) (Day) (Year)

7. **AGE** 3 Yrs. — Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work ~~School Boy~~
(b) General nature of industry, business or establishment in which employed (or employer) At home

9. **BIRTHPLACE** (State or Country) Idaho

10. **NAME OF FATHER** W J Kelly

11. **BIRTHPLACE OF FATHER** (State or Country) Utah

12. **MAIDEN NAME OF MOTHER** Adell Jenson

13. **BIRTHPLACE OF MOTHER** (State or Country) Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) W. J. Kelly
(Address) Weiser Idaho

15. Filed July 10 1920 W. R. Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July 4 1920
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ..... 19..., to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The **CAUSE OF DEATH*** was as follows:
Drowning feel in Irrigation ditch.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. L. Northam Coroner M. D.
7/5 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Hillcrest Cemetery | **DATE OF BURIAL** 7-6-1920

20. **UNDERTAKER** Northam McCaw | **ADDRESS** Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30994
Registered No. .....

1. PLACE OF DEATH.
County of Washington ~~Cambridge~~
City of Cambridge

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Baker.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. Aug 23 1866
(Month) (Day) (Year)

7. AGE 53 Yrs. 7 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Labor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Linn Co Mo

10. NAME OF FATHER Lafyette Baker

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Ester McCollum

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Perry Baker
(Address) Battle Ground Wash.

15. Filed June-16 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH March 7 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/27/20. 191..., to 3/7/20. 191..., that I last saw h.im alive on 3/6/20. 191..., and that death occured on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:
Uremic Convulsions; Chronic Interstitial Nephritis; Chronic Myocarditis
(Duration) 3 Yrs. — mos. — ds.
Contributory (Secondary) Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) W. H. Peterman M. D.
19..... (Address) Cambridge-Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cambridge Ida. | DATE OF BURIAL June 19 1920

20. UNDERTAKER Geo. Anderson | ADDRESS Cambridge Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS-YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 30995
Registered No.

1. PLACE OF DEATH
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Silas L Craddock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 15 (Day) 1869 (Year)

7. AGE: 50 Yrs. 11 Mos. 28 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): California

10. NAME OF FATHER: R C Craddock

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Martha A Childers

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm C. Craddock
(Address)

15.
Filed 19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10 1920, to April 17 1920, that I last saw h. im alive on April 15 1920, and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma - Large Intestine.

(Duration) Yrs. mos. ds.
Contributory (Secondary) Inanition.
(Duration) yrs. mos. ds.

(Signed) W. M. Peterson M. D.
19 (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge - Ida | DATE OF BURIAL: Apr 18 1920

20. UNDERTAKER: Jas Anderson | ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Adams
City of Indian Valley
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 30996
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William E Berry

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 23 1861
(Month) (Day) (Year)

7. AGE: 58 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Blacksmith
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Call

10. NAME OF FATHER: John H Berry

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Minerva Lindsey

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Berry
(Address) Indian Valley

15.
Filed 19
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 3d (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1920, to July 3 1920, that I last saw him alive on July 2 1920, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Arteria-sclerosis - Cardiac
Dilatation - Left Hemiplegia
(Duration) Yrs. mos. ds.
Contributory (Secondary) Cerebral Hemorrhage
(Duration) Yrs. mos. ds.

(Signed) J. H. Whiteman M. D.
19 (Address) Cambridge

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Valley, Ida. DATE OF BURIAL: 7/4/20 19

20. UNDERTAKER: Jas. Anderson ADDRESS: Cambridge Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30997

Registered No.

Registration District No.

Primary Registration District No.

(No. , St.)

1. PLACE OF DEATH

County of Washington

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claud R Love

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ (Write the word.)

6. DATE OF BIRTH: Sept 13 1896
(Month) (Day) (Year)

7. AGE: 23 Yrs. 6 Mos. 29 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: U S Soldier
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John B Love

11. BIRTHPLACE OF FATHER (State or Country): Scottland

12. MAIDEN NAME OF MOTHER: Inase A Perse

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Vernon Love
(Address) Cambridge Idaho

15.
Filed 19
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April 12 1926
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920, to Apr. 12 1920, that I last saw him alive on Apr. 12 1920, and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary) Pneumonia - Lobar

(Duration) Yrs. mos. ds.

(Signed) W. H. Pitman M. D.

19 (Address) Cambridge Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge - Idaho | DATE OF BURIAL: Apr. 13 1920

20. UNDERTAKER: Jas. Anderson | ADDRESS: Cambridge Ida

FORM V. S. No. 5-25 M. 1-19.

Pettingill

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2774

File No. 30999

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registered No. 72

1. PLACE OF DEATH

County of Ada.

City of Boise

(No. Soldiers Home Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William R. Burroughs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	White	Widower

6. DATE OF BIRTH

July (Month) 7 (Day) 1843 (Year)

7. AGE

77 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Civil War Veteran

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. G. Burnett

(Address) Boise Idaho.

15. Filed Jul 27 1920 L. P. Inman Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1919 to July 22 1920 that I last saw him alive on July 4 1920 and that death occurred on the date stated above, at 4. P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) 2 Yrs. 0 mos. 0 ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Roscoe C Ward M. D.

7-24 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	July 26 1920

20. UNDERTAKER	ADDRESS
Summers & Krebs	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31000

Registered No. 71

1. PLACE OF DEATH

County of Ada

City of Boise

(No. Broadway St. / St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henrietta L. Drennan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word.)

6. DATE OF BIRTH April 9th 1898 (Month) (Day) (Year)

7. AGE 22 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business or establishment in which employed (or employer) ...

9. BIRTHPLACE (State or Country) Cripple Creek, Colo

10. NAME OF FATHER John H. Suhlsen

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Amelia Neilsen

13. BIRTHPLACE OF MOTHER (State or Country) Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H Suhlsen

(Address) ...

15. Filed July 16 1920 L. P. Tinnan Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 14th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 2 1920 to July 14 1920

that I last saw her alive on July 14 1920

and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Pul. Tuberculosis

(Duration) ... Yrs. 4 mos. — ds.

Contributory (Secondary) Hepatic Cirrhosis

(Duration) 6 yrs. ... mos. ... ds.

(Signed) J. J. Pond M. D.

7/15 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery | **DATE OF BURIAL** 7/17 1920.

20. UNDERTAKER Simmbel & Sidenfaden | **ADDRESS** Boise

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 31001
Registered No. 70

1. PLACE OF DEATH
County of Ada
City of Fort Boise
(No. Soldiers Home, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Jackson Henderson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 2 (Month) (Day) 1834 (Year)

7. AGE: 86 Yrs. 2 Mos. 10 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: David Henderson

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Anna Piatte

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Vernon Reynolds
(Address) Boise Ida

15. Filed July 14 1920 L. O. Pinman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 12 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/1/19 19..., to 7-12- 19 20
that I last saw him alive on 7 10 19 20
and that death occurred on the date stated above, at 1 10 M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) H. Pittenger M. D.
7/13 19 20 (Address) Boise Land Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 14 1920
20. UNDERTAKER: Summers & Kirtley — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2054
File No. 31002
Registered No. 69

1. PLACE OF DEATH
County of Ada
City of
If death occurs away from usual residence, give facts called for under special information.
(No. 3 mi. N.E. of Star St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Caroline Taylor.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White.	Widow.

6. DATE OF BIRTH: Jan 2 (Month) (Day) 1835 (Year)

7. AGE: 85 Yrs. 6 Mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Israel Banks.

11. BIRTHPLACE OF FATHER (State or Country): Vermont.

12. MAIDEN NAME OF MOTHER: Mary Clothier.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs O A Jones
(Address)

15. Filed Jan 9 1920 L. P. Stewart Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 6 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1920, to June 30 1920
that I last saw h[illegible] alive on June 30 1920
and that death occurred on the date stated above, at 5.30 P. M.
The CAUSE OF DEATH* was as follows:

Asthenia.

(Duration) Yrs. 7 mos. ds.
Contributory (Secondary) Old age

(Duration) yrs. mos. ds.

(Signed) Old Hall, M. D.
July 9 1920. (Address) Star, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
Ames Iowa	

20. UNDERTAKER	ADDRESS
Summers & Webb.	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31003
Registered No. 68

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

(No. North West of Boise St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jeanne Pottet

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Single

6. DATE OF BIRTH: Sep (Month) 11 (Day) 1906. (Year)

7. AGE: 13 Yrs. 9 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Iven A. Pottet

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Lala Hitt

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. G. M. McPherson
(Address) Weiser Idaho.

15. Filed July 7 1920 L. O. Jensen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19— to ——— 19—, that I last saw her ~~alive~~ dead on July 4 1920, and that death occurred on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:
Fracture of skull.
Automobile accident.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Clyde E. Summers, Coroner M. D.
(Address) Boise Idaho. Harry Hoff Deputy

7/6 1920

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	19
20. UNDERTAKER: Summers & Webb	ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3104

Registered No. 67

1. **PLACE OF DEATH**

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Milton B. Atkinson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. (No. 12 West Pierce Park St.)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male.

4. **COLOR OR RACE** White.

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married (Write the word.)

6. **DATE OF BIRTH** Sept 17 — 1847
(Month) (Day) (Year)

7. **AGE** 72 Yrs. 9 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Rancher,
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Penn.

10. **NAME OF FATHER** James Atkinson

11. **BIRTHPLACE OF FATHER** (State or Country) England.

12. **MAIDEN NAME OF MOTHER** Lizzie Clough.

13. **BIRTHPLACE OF MOTHER** (State or Country) Penn.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) W. McBratney
(Address) Boise Idaho,

15. Filed July 6 1920 L. P. D. Local Registrar

(SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088)

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July 5 — 1920.
(Month) (Day) 19 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 1910, to July 4th, 1920.
that I last saw him alive on July 2nd. 1920
and that death occurred on the date stated above, at 8 a M.
The CAUSE OF DEATH* was as follows:
Paralysis and Senility,
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. S. Gregory M. D.
7/5 1920. (Address) Boise Idaho.

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal** or **Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Morris Hill Cemetery — **DATE OF BURIAL** 7/7 1920.

20. **UNDERTAKER** Wm McBratney — **ADDRESS** Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

(7) (8)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37095

Registered No. 66

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. R. D. #4 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George W Yenne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1852 (Year)

7. AGE: 67 Yrs. 8 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): General farm work.

9. BIRTHPLACE (State or Country): Knob Fork West Virginia

10. NAME OF FATHER: Joseph Yenne

11. BIRTHPLACE OF FATHER (State or Country): Little York Pennsylvania

12. MAIDEN NAME OF MOTHER: Rebecca Anne Santee

13. BIRTHPLACE OF MOTHER (State or Country): Monongalia Co. Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sam Yenne

(Address) R. D. #4 Boise Idaho

15. Filed July 3 1920 L. O. Pinneo Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/30 1920, to 7/2 1920, that I last saw h[illegible] alive on 7/1 1920 and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Pulmonary Embolism

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Traumatic Injury to Chest.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Tidwell M. D.

7/3 1920 (Address) Boise Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 7/4 1920

20. UNDERTAKER: Schreiber & Sidentader | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

Pettingyer

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31006

Registered No. 268

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 1064

(No. 1214 N. 13. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Elvis Schooler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: July (Month) 27 (Day) 1854 (Year)

7. AGE: 66 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate
(b) General nature of industry, business or establishment in which employed (or employer): Dealer.

9. BIRTHPLACE (State or Country): Ino

10. NAME OF FATHER: Schooler

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cleo J. Schooler
(Address) Boise, Idaho

15. Filed July 28 1920 L. O. Truman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1920, to July 27 1920. that I last saw h[illegible] alive on July 27 1920, and that death occurred on the date stated above, at 8.0 M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Carl Hill M. D.

7/28/20 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 29 1920

20. UNDERTAKER: Summers & Trebs — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31007

Registered No. 206

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No.) St Lukes Hospital

• If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Ratliff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Widowed, Divorced or Single)

6. DATE OF BIRTH: Aug 16 (Month) (Day) 187? (Year)

7. AGE: 42 Yrs. 11 Mos. [illegible] Ds. 9

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Robert Ratliff

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Susan Grisham

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos Ratliff

(Address) .....

15. Filed July 24 1920 L. O. Inman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1920, to July 25 1920 that I last saw h[illegible] alive on July 24 1920 and that death occurred on the date stated above, at 6A M.

The CAUSE OF DEATH* was as follows:

Operation for Ulcer of Stomach

..... (Duration) 12 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Falleman M. D.

7/25 1920 (Address) Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bruneau Idaho. DATE OF BURIAL: July 27 20.

20. UNDERTAKER: Summers & Gebs. ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31008
Registered No. 265

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410, State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chris Farrell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: about (Month) (Day) 1845 (Year)

7. AGE: about 75 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Mc Clannels

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Schreiber
(Address) Boise

15. Filed July 23 1920 L. O. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1917, to July 18 1920, that I last saw h— alive on July 18 19—, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Cancer of bladder

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. D.
19 (Address) Fir Calcuta

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death? Silver City
Former or usual residence Silver City Ida.

19. PLACE OF BURIAL OR REMOVAL: St Johns cemetery — DATE OF BURIAL: 7/24 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

Collister

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31009
Registered No. 204

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 415, Washington St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Doerr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: July (Month) 22nd (Day) 1920 (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many 5 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: J. G. Doerr

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Maud J. Muller

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. G. Doerr
(Address) Boise

15. Filed July 23 1920 L. O. Inman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1920, to July 22 1920, that I last saw him alive on July 22 1920, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Premature birth, complicated with congenital heart defect.

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary) Patent Foramen ovale (Duration) ....yrs. ....mos. ....ds.

(Signed) L. P. McCall M. D.

July 23 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	7/24 1920
20. UNDERTAKER	ADDRESS
Terreiba & Heidenfelder	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 115 N. 18 St.)

File No. 31010

Registered No. 263

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lemuel Wilcox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan 3 (Month) (Day) 1860 (Year)

7. AGE: 60 Yrs. 6 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Calvin Wilcox

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sarah Randall

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Raleigh Wilcox

(Address) Kansas City Mo

15. Filed July 20 1920 L. P. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1920 to July 18 1920 that I last saw him alive on July 18 1920 and that death occurred on the date stated above, at 12 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Peters M. D.

7/9 1920 (Address) Ossland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill DATE OF BURIAL: July 20 1920

20. UNDERTAKER: Summers & Clark ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31011
Registered No. 262

Registration District No. 2
Primary Registration District No. 1004

1. PLACE OF DEATH
County of Ada
City of Boise (No. 410 Lake St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emmaline S. Allen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: August (Month) 14 (Day) 1844 (Year)

7. AGE: 76 Yrs. 11 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Smith Johnson

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Zeba Johnson

13. BIRTHPLACE OF MOTHER (State or Country): U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nellie E Davis
(Address) Glenns Ferry Ida

15. Filed 7/28 1920 L.B. Forman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/12 1920 to 7/18 1920 that I last saw h[illegible] alive on 7/18 1920 and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Senile Gangrene of Left Foot

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

7/19 1920 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Glenns Ferry Ida
Former or usual residence Dupont Ill

19. PLACE OF BURIAL OR REMOVAL: Dupont Ill. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Schreiber & Hidenfeldt ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31012
Registered No. 261

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1,04
(No. 411 Washington St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Antonia Ubernaga

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 10 (Day) 1919 (Year)

7. AGE: 1 Yrs. ____ Mos. 6 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: Juan Ubernaga

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Juana Arriola

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Juan Ubernaga
(Address) 211 South 6th Boise

15. Filed July 17 1920 L. O. Jenner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/7 1920 to 7/16 1920
that I last saw her alive on 7/16 1920
and that death occurred on the date stated above, at ____ M.
The CAUSE OF DEATH* was as follows:

Septic Sore Throat
Infection following
(Duration) Yrs. ____ mos. ____ ds.
Contributory (Secondary) Measles
(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H. H. Kitchey M. D.
7/17 1920 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 7/18 1920

20. UNDERTAKER: Schreiber & Hedenstedt — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1904
File No. 31013
Registered No. 280

1. PLACE OF DEATH
County of Ada
City of Boise
(No. St. Alphonsus Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer E. Laursen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

6. DATE OF BIRTH: Feb (Month) 6 (Day) 1902 (Year)

7. AGE: 18 Yrs. 5 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: S. J. Laursen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Anna Oliver

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. J. Laursen
(Address) R.D. #4 Boise

15. Filed July 17 1920 F. O. Inman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1920 to July 15 1920 that I last saw h.l.xxx. alive on July 15 1920 and that death occurred on the date stated above, at 11½ A. M.

The CAUSE OF DEATH* was as follows:
Broken neck. Spinal cord broken lower cervical portion.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. A. McCalla M. D.
7/16 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 18 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31014
Registered No. 259

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 2601 W Ada St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. Hartman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct 27 1858 (Month) (Day) (Year)

7. AGE: 61 Yrs. 8 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Ernest Hartman.

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Anna Seibert

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna Hartman.
(Address) 2601 Adams St. Boise Ida.

15. Filed July 17 1920 L. O. James Local Registrar

SIMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1920, to July 16 1920
that I last saw him alive on July 16 1920
and that death occurred on the date stated above, at 9 a. M.
The CAUSE OF DEATH* was as follows:
Cardiac decompensation
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) R. J. Cuen M. D.
7-17 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parma Idaho — DATE OF BURIAL: July 19 1920
20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31015

Registered No. 257

Registration District No. 2

Primary Registration District No. 1004

1. **PLACE OF DEATH**

County of Ada

City of Boise

(No. 110 E Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Myers Coffin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Widow

6. DATE OF BIRTH: July (Month) 3 (Day) 1819 (Year)

7. AGE: 101 Yrs. 0 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: John Myers.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Mary.

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas McLaffin

(Address) 819 N. 19. st Boise Ida

15. Filed July 17 1920 L. O. Truman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ July 16 1920 to ..... 19..... that I last saw her ~~alive~~ dead on July 16 1920 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner M. D.

7/17 1920, (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill DATE OF BURIAL: July 18 1920.

20. UNDERTAKER: Summers & Turk ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31016

Registered No. 256

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1708 N 18 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sophia M. Clapp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: July (Month) 5 (Day) 1834 (Year)

7. AGE: 86 Yrs. 0 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John T. Thorp

11. BIRTHPLACE OF FATHER (State or Country): Conn

12. MAIDEN NAME OF MOTHER: Harriet Abbatt

13. BIRTHPLACE OF MOTHER (State or Country): New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Lillian L Hale

(Address) 1708 N 18 St Boise Ida

15. Filed July 17 1920 L. P. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1920 to July 15 1920

that I last saw her alive on July 15 1920

and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorhage

(Duration) ——— Yrs. ——— mos. 3 ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ? yrs. ? mos. ? ds.

(Signed) F Willis Almond M. D.

7/17 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 2 yrs. — mos. — days

Where was disease contracted if not at place of death? ?

Former or usual residence ?

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 17 1920

20. UNDERTAKER: Summers & Hurd — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31017

Registration District No. 2
Primary Registration District No. 204
Registered No. 254

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth B. Courson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: Feb 17 (Month) (Day) 1870 (Year)

7. AGE: 50 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Henry J. Bahlman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dorothea Coleman

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harold S. Courson
(Address) Boise, Ida. RFD 1

15. Filed 7/14 1920 L. A. Thomas
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1920 to July 14 1920 that I last saw h..... alive on July 14 1920 and that death occurred on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Operation for Erysipelas in goitre
(Duration) ..... yrs. ..... mos. 21 ds.

(Signed) James L. Clemens M. D.
7/16 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: July 17 1920

20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31018
Registered No. 240

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Chester Opie
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 8 (Day) 1892 (Year)

7. AGE: 28 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bower, Neb.

10. NAME OF FATHER: Isaac Opie

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Jennie Jones

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse L Opie.
(Address) Meridian Ida.

15. Filed July 3 1920 — L. O. Gunn — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 12:05 a.m. 1920 to July 1 12:10 a.m. 1920
that I last saw him alive on " " 1920,
and that death occurred on the date stated above, at 12:10 A.M.
The CAUSE OF DEATH* was as follows:
Shock following internal hemorrhage - bullet wound.

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) John F. Rutledge M. D.
19 ... (Address) St. Alphonsus Hosp.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 7/4 1920

20. UNDERTAKER: Schreiber & Siebenthaler — ADDRESS: Boise

FORM V. S. No. 5-25 M. 1-19.

French

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31019
Registered No. 241

1. PLACE OF DEATH
County of Ada
City of Boise
(No. St Lukes Hospital)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Bruce
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 15 (Day) 1848 (Year)

7. AGE: 72 Yrs. 1 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Scotland.

10. NAME OF FATHER: Evan

11. BIRTHPLACE OF FATHER (State or Country): Scotland.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Bruce
(Address) 1216 E State St

15. Filed July 3 1920 L. O. Truman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1920, to July 2 1920, that I last saw her alive on July 2 1920 and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH was as follows:
Apoplexy
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) P P French M. D.
July 3 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: July 4 1920

20. UNDERTAKER: Summers & Kibbe. ADDRESS: Boise Ida.

FORM V. S. No. 5-25 M. 1-19.

Stewart

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 31020

Registered No. 242

1. PLACE OF DEATH

County of Ada

City of Boise

(No. St Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles E. Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

6. DATE OF BIRTH: July — 1845
(Month) (Day) (Year)

7. AGE: 75 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James Jackson

11. BIRTHPLACE OF FATHER (State or Country): North Carolina.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James A Jackson
(Address) .....

15. Filed July 3 1920 L O Green
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 2 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920 to July 2 1920
that I last saw h..... alive on ..... 19....,
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows: General Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Stewart M. D.

7/3 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Iowa City, Iowa.

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Summers & Webb.

ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31021

Registered No. 243

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. St Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha S Kinkaid.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	W	Married (or Widowed)

6. DATE OF BIRTH: Feb (Month) 8 (Day) 1877 (Year)

7. AGE: 43 Yrs. 4 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: J. F. Stanton

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Sarah A. Slater

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Royal A. Stanton
(Address) .....

15. Filed 7/7/1920 19 20 — R. Thurman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1920, to July 4 1920, that I last saw h.er alive on July 4 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows: Shock, following auto accident

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. A. Cluen M. D.

7-6 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: July 7 1920

20. UNDERTAKER: Summers & Hobbs. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31022

Registered No. 245

Registration District No. 2

Primary Registration District No. 104

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Bailey Kidd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: December 11 (Month) (Day) 1891 (Year)

7. AGE: 28 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Robert H. Bailey

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Laura A. Harris

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. C. Kidd

(Address) Beaumeau Ada

15. Filed July 10 19[illegible] L. O. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920 to July 8 1920 that I last saw h. alive on July 8 1920 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Pelvic abscess from tubal infection

(Duration) ... Yrs. 7 mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) M. H. Tallman M. D.

7/9 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: 7/10 1920

20. UNDERTAKER: Schreiber & Sidenbender ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31023
Registered No. 246

1. **PLACE OF DEATH**
County of Ada
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

(No.) St. Alphonsus, Hospital

2. **FULL NAME** Lester Gay Black,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male.

4. **COLOR OR RACE** White.

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.) Married.

6. **DATE OF BIRTH** July — 11 — 1885
(Month) (Day) (Year)

7. **AGE** 34 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Minister of
(b) General nature of industry, business or establishment in which employed (or employer): Baptist Church.

9. **BIRTHPLACE** (State or Country) Iowa

10. **NAME OF FATHER** William Black.

11. **BIRTHPLACE OF FATHER** (State or Country) Indiana

12. **MAIDEN NAME OF MOTHER** Jane Lozier

13. **BIRTHPLACE OF MOTHER** (State or Country) Illinois.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs. L. G. Black.
(Address) Weiser. Idaho.

15. Filed July 10 1920 L. P. Grimes
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July 7 — 1920
(Month) (Day) 19 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from June 14 1920 to July 7 1920
that I last saw h.. alive on July 7 1920
and that death occurred on the date stated, above, at 5:30 P.M.
The CAUSE OF DEATH* was as follows:
Chronic nephritis
Abortion (Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ralph Foltz M. D.
7-9 1920. (Address) Boise Idaho.

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Galesburg, Ill. | **DATE OF BURIAL** ..... 19.....

20. **UNDERTAKER** W. M. Bratney | **ADDRESS** Boise Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31024

Registered No. 267

1. **PLACE OF DEATH**

County of Ada

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. St. Alukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** John Hopkins.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Widower.

6. **DATE OF BIRTH** Nov 26. 1869
(Month) (Day) (Year)

7. **AGE** 50 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Cook.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. **BIRTHPLACE** (State or Country) Canada

10. **NAME OF FATHER** Unknown

11. **BIRTHPLACE OF FATHER** (State or Country) Unknown.

12. **MAIDEN NAME OF MOTHER** Unknown.

13. **BIRTHPLACE OF MOTHER** (State or Country) Unknown.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs Alice Slater.
(Address) 612 So 13 St.

15. Filed July 26 1920 L. O. Quinn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July 23 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1920 to July 23 1920 that I last saw h. alive on July 23 1920 and that death occurred on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs
following an acute attack of
asthma

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic bronchial Asthma

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas Bond M. D.

7-24 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Morris Hill Cemetery — **DATE OF BURIAL** July 26, 20

20. **UNDERTAKER** Summers & Webb. — **ADDRESS** Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31025
Registered No. 250

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 106 East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose E. Arnold Riddle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH: February 25th 1850 (Month) (Day) (Year)

7. AGE: 70 Yrs. Mos. 4 ds. 23

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dress
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Springfield Illinois

10. NAME OF FATHER: Geo Arnold

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Elvira Sanford

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [signature]
(Address) 108 Warm Springs Ave Boise Idaho

15. Filed July 13 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 13th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1920, to July 13 1920, that I last saw her alive on July 13 1920, and that death occurred on the date stated above, at 9.15 M.

The CAUSE OF DEATH* was as follows:
Carcinoma of uterus

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Carcinoma

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. P. McCall M. D.
7/13 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Minneapolis Minn	7/13 1920
20. UNDERTAKER	ADDRESS
Schreiber & Lieuallen	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2007

File No. 31026

Registered No. [illegible]

1. PLACE OF DEATH

County of Ada.

City of Boise.

(No. U.S. Public Health Service. St.)

Hospital or Institution

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John R. Kilk.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan. 30 (Month) (Day) 1896 (Year)

7. AGE: 24 Yrs. 6 Mos. 4 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise. Idaho.

10. NAME OF FATHER: G. R. Kilk.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Ina Hunter

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William McBratney

(Address) Boise, Idaho,

15. Filed Aug 6 1920 R. H. Pate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 4 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 27 1920 to Aug 4 1920 that I last saw h[illegible] alive on Aug 4 1920, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis pulmonary

Tuberculosis Bronchial Tubes

Tuberculosis Lymphatic

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) Pneumonia

(Duration) — yrs. 4 mos. — ds.

(Signed) Harry L. Wells M. D.

8/6 1920. (Address) Surgeon in Charge. Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/6 1920.

20. UNDERTAKER: W. McBratney — ADDRESS: Boise. Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1075
File No. 31027
Registered No. 258

1. PLACE OF DEATH
County of Ada
City of Boise
(No. U.S.P.H.S. Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Jones
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White	Single

6. DATE OF BIRTH Don't Know (Month) (Day) 1 (Year)

7. AGE 28 Yrs. — Mos. — ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Returned
(b) General nature of industry, business or establishment in which employed (or employer): Soldier

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise, Idaho.

15. Filed July 17 1920 L. R. Furman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 15 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 28 1920 to July 15 1920 that I last saw him alive on July 15 1920, and that death occurred on the date stated above, at 4.35 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis, pulmonary acute.
(Duration) 2 Yrs. 1½ mos. — ds.
Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) A. J. Bentheen M. D.
7-15 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. 1 mos. 17 days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	7-18 1920
20. UNDERTAKER W. McBratney	ADDRESS Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31088
Registered No. 244

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dennis Whelan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W.	Married

6. DATE OF BIRTH April 16 (Month) (Day) 1863 (Year)

7. AGE 57 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Jas Whelan

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Elizth Whitty

13. BIRTHPLACE OF MOTHER (State or Country) Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Alice Whelan

(Address) 1703 N. 13th St.

15. Filed July 12 1920 L. P. Gunn Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 9th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920 to July 9 1920 that I last saw h... alive on July 8 1920 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia
following Appendicitis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) A A Higgs M. D.

7-9 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. 27 days. In the State ... yrs. ... mos. ... days

St Alphonsus Hospital

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL St Johns Cemetery | **DATE OF BURIAL** 7/12 1920

20. UNDERTAKER Schreiber & Sidenfaden | **ADDRESS** Boise Idaho

Higgs

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1604
File No. 31029
Registered No. 248

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1606 No 5 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William N. Rogers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct 18 (Month) 1915 (Day) 1 (Year)

7. AGE: 4 Yrs. 7 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Henry R. Rogers

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Dora Schoenwald

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. R. Rogers
(Address) .....

15. Filed July 12 1920 L. P. French Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 10 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29, 1920, to July 10 1920
that I last saw him alive on July 10 19 ....
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Scarlet Fever
.....
.....
.....(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) P P French M. D.
July 12 1920 (Address) 417 Overland Bldg. Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: July 11 1920

20. UNDERTAKER: Summerour & Cobb.
ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31030
Registered No. 249

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. St Alphonsus Hosp St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arvilla T. Brofford.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F.	White.	Married (or Widowed).

6. DATE OF BIRTH: Oct 7 (Month) (Day) 1870 (Year)

7. AGE: 49 Yrs. 9 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Geo Hister

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Susan Alexander

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Brofford

(Address)

15. Filed July 13 1920 L. P. Inman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 12 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11 1920 to July 12 1920 that I last saw her alive on July 12 19.... and that death occurred on the date stated above, at 7:10 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid flecture of Colon

(Duration) Yrs. 8 mos. ds.

Contributory (Secondary) Intestinal Obstruction and Peritonitis

(Duration) yrs. mos. 2 ds.

(Signed) T. M. Braxton M. D.

July 13 1920 (Address) Boise.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	July 15 1920
20. UNDERTAKER	ADDRESS
Simmons & Cobb.	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31031
Registered No.

1. PLACE OF DEATH

County of Ada.

City of Star.

(No. Star St.)

Registration District No. 9

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecil H. Birch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: June (Month) 9 (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 20 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Ernest H. Birch

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Olive M. Elmore

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ernest H Birch

(Address) Star, Ida

15. Filed July 29 1920 Frederic K. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 9 1920 to July 29 1920 that I last saw h. alive on July 26 1920 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Bleeding of the navel cord

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John Baer M. D.

7-29-1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Star, Idaho

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery — DATE OF BURIAL: July 30 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

Dr. Beck

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31032
Registered No. .....

1. PLACE OF DEATH.
County of Ada
City of Star
(No. ....., ... St.)
Registration District No. 9
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information. 7, 27, 1920

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Norcissie Elezabeth Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. May (Month) 31 (Day) 1833 (Year)

7. AGE: 87 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: J W Howe

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Sarah Williams

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Roda Breshears
(Address) Eagle R 1

15. Filed July 30 1920 Frederick L Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1920, to July 18 1920, that I last saw h alive on July 18 1920, and that death occured on the date stated above, at 9:30 P M.

The CAUSE OF DEATH was as follows:*
Senility
(Duration) Mayo yrs. mos. ds.
Contributory (Secondary) Acute Regurgetate
(Duration) May yrs. mos. ds.
(Signed) C C Hall M D.
7/28 1920 (Address) Star Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Idaho — DATE OF BURIAL: July 30 1920
20. UNDERTAKER: Summers & Treb — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

County of Caribou

Primary Registration District No. 2048

File No. 31033

City of Soda Springs (No. Dr. Rackley Hospital)

Registered No. XX 13

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillian L. Turner

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Exact date unknown 1893
(Month) (Day) (Year)

7. AGE: 37 yrs. ..... mos. ..... ds. as known. IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E. J. Broadbent

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Sadie Hausy

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Turner
(Address) Grace Ida

15.
Filed June 30 1920 Ellis Kasey
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 30 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1920, to June 30 1920
that I last saw h-r alive on June 30 1920
and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Hemorrhage due to
Incomplete Miscarriage

(Duration) ..... yrs. ..... mos. 2 / ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ellis Kasey M. D.

19 ..... (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah | DATE OF BURIAL: July 4 1920

20. UNDERTAKER: Schumacher & Hay | ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
File No. 31034
Registered No. 12

1. PLACE OF DEATH.
County of Caribou
City of Soda Springs (No. Residence St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alonzo Heath

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	married

6. DATE OF BIRTH
January 14 1871
(Month) (Day) (Year)

7. AGE
49 yrs. 5 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Mining
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Salt Lake City Utah

10. NAME OF FATHER Henry Heath

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER Sarah Ann Bird

13. BIRTHPLACE OF MOTHER
(State or Country) St Johns Newfoundland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alonzo Heath
(Address) Soda Springs

15.
Filed June 17. 1920 Ellis Kackley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 16 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1920, to June 16 1920
that I last saw her alive on June 16 1920
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

Contributory (Secondary) None
(Duration) yrs. mos. ds.

(Signed) Ellis Kackley M. D.
Jun 17 1920 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake City Utah	Jun 18 1920

20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

File No. 31035

County of Gooding

City of Soda Springs (No. ....., ... St.)

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Zora Egbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED, WIDOWED~~ OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1882 (Year)

7. AGE: 37 yrs. 9 mos. 14 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: J. L. Pickett

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Laura A. Hulsborn

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Egbert
(Address) Grace, Idaho

15.
Filed Aug 26 1920 Eric Kaercher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1915, to Aug. 12 1920, that I last saw h.s. alive on Aug 8 1920 and that death occurred on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary): None

(Duration) 10 yrs. — mos. — ds.

(Signed) Eric Kaercher M. D.

Aug 12 1920 (Address) Soda Springs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Thatcher Idaho — DATE OF BURIAL: Aug 15 1920

20. UNDERTAKER: None — ADDRESS: —

1. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 31036
Registered No.

1. PLACE OF DEATH
County of Ada
City of Meridian
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Willard D Rea

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March 21 (Month) (Day) 1920 (Year)

7. AGE: ..... Yrs. 5 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Meridian Idaho

10. NAME OF FATHER: Robert Rea

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Myrtle Walker

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Rea
(Address) Meridian Id.

15. Filed Aug. 21 1920 Alice A. Sutton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 20 1920 to Aug 20 1920 that I last saw him alive on Aug 20 1920 and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Whooping Cough
..... (Duration) Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Bronchopneumonia
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. L. Sutton M. D.
8/20 1920 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: Aug 21 1920

20. UNDERTAKER: W. E. Stutzman — ADDRESS: Meridian Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 203
File No. 31037
Registered No.

1. PLACE OF DEATH
County of Ada.
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Bertram Saunders

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan. (Month) 12. (Day) 1920 (Year)

7. AGE: ..... Yrs. 8 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Meridian Id.

10. NAME OF FATHER: Benj. B. Saunders.

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Tillie Suckau

13. BIRTHPLACE OF MOTHER (State or Country): Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benj. B. Saunders
(Address) Meridian Idaho

15. Filed Aug. 16 1920 Alice A. Pattee Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1920, to Aug 14 1920
that I last saw him alive on Aug 14 1920
and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Cer. Hemorrhage
.....
.....
.....(Duration) .....Yrs. .....mos. 3 ds.
Contributory (Secondary) .....
.....(Duration) .....yrs. .....mos. .....ds.
(Signed) W. F. Neal M. D.
8-15 1920 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery — DATE OF BURIAL: Aug 16 1920

20. UNDERTAKER: W. D. Mater — ADDRESS: Meridian Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 11

Primary Registration District No. 2003

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31038

Registered No. .....

1. PLACE OF DEATH

County of Ada

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geneva Burri

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Aug (Month) 13 (Day) 1897 (Year)

7. AGE: 23 Yrs. 11 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: Fred Yoder

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: Fannie Yoder

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm F Burri

(Address) Nampa Ida

15. Filed July 30 1920 Alice A. Hutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1920 to July 24th 1920 that I last saw her alive on July 18th 1920, and that death occurred on the date stated above, at 1:40 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Influenza

(Duration) 0 Yrs. 0 mos. 18 ds.

Contributory (Secondary) Acute Pulmonary Tuberculosis

(Duration) 0 yrs. 7 mos. 0 ds.

(Signed) Geo. [illegible] M. D.

July 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: 7-25 1920

20. UNDERTAKER: Meridian F. H. Robinson — ADDRESS: Nampa Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31039
Registered No.

1. PLACE OF DEATH
County of Ada.
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 14
Primary Registration District No. 2003
(No. ..... St.)

2. FULL NAME William P Bennett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: April (Month) 1 (Day) 1853 (Year)

7. AGE: 67 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Caldwell Co Missouri

10. NAME OF FATHER: William Bennett

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Hannah Lane.

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ethel Prestwich
(Address) Meridian Ida.

15. Filed July 6 1920 Alice A. Dutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920 to July 1st 1920 that I last saw him alive on July 1st 1920 and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:
Flu Pneumonia Uræmia
Chronic Interstitial Nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Interstitial Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. L. Dutton M. D.
7/2 1920 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery | DATE OF BURIAL: July 7 1920

20. UNDERTAKER: W S Mater | ADDRESS: Meridian

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2003
File No. 31040
Registered No.

1. PLACE OF DEATH
County of Ada
City of Meridian (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jack J. Byers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Apr. (Month) 4 (Day) 1918 (Year)

7. AGE: 1 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Co.

10. NAME OF FATHER: J. J. Byers.

11. BIRTHPLACE OF FATHER (State or Country): Ada Co Idaho

12. MAIDEN NAME OF MOTHER: Florance Eslick

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. J. Byers
(Address): Meridian

15. Filed June 16 1920 Alice A. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1920, to June 16 1920, that I last saw him alive on June 16 1920, and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Toxemia

(Duration) Yrs. mos. ds.

Contributory (Secondary) Scarlet Fever

(Duration) yrs. 2 mos. ds.

(Signed) W. F. Neal M. D.

6-16 1920 - (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Ada | DATE OF BURIAL: June 18 1920

20. UNDERTAKER: Schweiber & Siddufaden | ADDRESS: Boise

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 34041
Registered No. 3348

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 306 - 7th 3 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Buchanan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: April (Month) 4. (Day) 1881 (Year)

7. AGE: 39 Yrs. 7 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Geo Buchanan

11. BIRTHPLACE OF FATHER (State or Country): Kansas City.

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): Kansas City Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J Belle Anderson
(Address) 306 - 7th 3 Ave

15. Filed 7/3 1920
Eva Bacon
Dep., Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 5 15 M.
The CAUSE OF DEATH* was as follows:

Gun Shot Wound by
Goodie Davis
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John A Luther M. D.
19..... (Address) Alling Colonia

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: July 3 1920

20. UNDERTAKER: Mell D Walker. — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31042

Registered No. 3349

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. 144 No 11 ave St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Hill.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April 24 1871
(Month) (Day) (Year)

7. AGE: 49 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cumberland Pa

10. NAME OF FATHER: Geo Hill

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs M E Cutler
(Address) 144 No 11 ave

15. Filed 7/6 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 4 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Death caused from
Heart. (Myocarditus)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
19..... (Address) White Corner Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: 7/8 1920

20. UNDERTAKER: Neil J Walker — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 84

Primary Registration District No. 2141

File No. 39043

County of Bannock

City of Lava Hot Springs (No. ....., ... St.)

Registered No. 3351

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herschel Floyd Skaggs

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: October 28 1911 (Month) (Day) (Year)

7. AGE: 8 yrs. 8 mos. 7 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cnadorko Okla

10. NAME OF FATHER: M B Skaggs

11. BIRTHPLACE OF FATHER (State or Country): Ellis Mo.

12. MAIDEN NAME OF MOTHER: Estella L Rossell

13. BIRTHPLACE OF MOTHER (State or Country): Neosho Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): L L Skaggs
(Address): Pocatello Idaho

15. Filed 7/7/20 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 5th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from .....191..., to .....191...,
that I last saw h..... alive on .....191...,
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning

.....(Duration).....yrs.....mos.....ds.

Contributory
(Secondary)

.....(Duration).....yrs.....mos.....ds.

(Signed) John A Zupp M. D.
7-7 1920 (Address) Lava Hot Springs

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Mountain View | DATE OF BURIAL: July 7 1920

20. UNDERTAKER: [illegible] | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bunch
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. Bannock Ada St.)

File No. 31044
Registered No. 3357

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dave D Stephens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 25 (Day) 1877 (Year)

7. AGE: 43 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montpelier

10. NAME OF FATHER: Chas Stephens

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ellen Dowd

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas N Stephens
(Address) Montpelier Ida

15. Filed 7/7 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1920, to July 5 1920, that I last saw h. alive on July 5 1920, and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:
Fracture Base of Skull.

(Duration) — Yrs. — mos. 8 hrs

Contributory (Secondary) Internal injuries

(Duration) — yrs. — mos. 8 ds.

(Signed) J H Lyman M. D.

July 6 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida. DATE OF BURIAL 19

20. UNDERTAKER: Winnekers ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 214
File No. 34045
Registered No. 2332

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No.) St. Anthony Hospital

If death occurred away from usual residence, give facts called for under special information.

2. FULL NAME Michael F. Hallen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH Feb (Month) 14th (Day) 1847 (Year)

7. AGE 73 yrs. 4 mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER David Hallen

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Barry

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Hallen
(Address) Inkom Idaho

15. Filed 7/8 1926 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 6 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1926 to July 6 1926
that I last saw h alive on July 5 1926
and that death occurred on the date stated above, at 7.0 M.

The CAUSE OF DEATH* was as follows:

Carcinoma Pylorus

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. A. Coughlin M. D.

19 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Columbus Mont	July 8 1926
20. UNDERTAKER	ADDRESS
Chamberlain Undertaking Co	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 716
File No. 21016
Registered No. 3355

1. PLACE OF DEATH

County of Bannock
City of Pocatello (No. Riverside Hotel Lava St. Hot Springs)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Woodman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Widower

6. DATE OF BIRTH: March (Month) not Known (Day) 84 (Year)

7. AGE: 79 Yrs. 3 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Johnson
(Address) Buhl Idaho.

15. Filed July 3 1920 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-19 1920, to 7-2 1920, that I last saw him alive on 7-2 1920, and that death occurred on the date stated above, at 10:45 P.M.

The CAUSE OF DEATH* was as follows: Traumatism of Heart (Toe Nail Bath) (acute dilatation of heart?)

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) T. Wigleworth M. D.

7-3 1920 (Address) Lava Hot Springs

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 14 days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Buhl Idaho

19. PLACE OF BURIAL OR REMOVAL: Buhl Idaho — DATE OF BURIAL: July 5 1920

20. UNDERTAKER: H. L. McKay — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 31047
Registered No. 3357

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 409 N. 8th St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Evans

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Mar 1 1835
(Month) (Day) (Year)

7. AGE: 85 yrs. 4 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business, or dstablishment in which employed (or employer): Housewife

9. BIRTHPLACE (State or Country): S. Wales

10. NAME OF FATHER: John Evans

11. BIRTHPLACE OF FATHER (State or Country): S. Wales

12. MAIDEN NAME OF MOTHER: Jane Davis

13. BIRTHPLACE OF MOTHER (State or Country): S. Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Evans
(Address) 409 N. 8th St.

15. Filed 7/9 1920
Dan Cox Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3d 1920, to July 8 1920,
that I last saw her alive on July 3 1920,
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Cardio-Vascular renal disease

(Duration) 10 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. A. Sprague M. D.
July 9 1920 (Address) Kohlerby, Pocatello, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: July 9 1920

20. UNDERTAKER: Schumacher Hall — ADDRESS: Pocatello

July

SYMS - YORK CO., PTRS & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2164
File No. 21048
Registered No. 33

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 1221 N. Garfield St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Ruby Hines

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 22 1920 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: Benjamin Hines

11. BIRTHPLACE OF FATHER (State or Country): Blackfoot Ida

12. MAIDEN NAME OF MOTHER: Hannah Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Firth Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Benjamin Hines
(Address) 1221 N. Garfield

15. Filed June 12 1920 J. R. Steed Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 9 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 22 1920, to June 9 1920, that I last saw her alive on June 9 1920, and that death occurred on the date stated above, at 3:45 P. M.

The CAUSE OF DEATH* was as follows:

~~Pneumonia~~
Blue Baby - -

(Duration) Yrs. mos. 18 ds.

Contributory (Secondary) Prematurity (7 to 8 mo.)

(Duration) yrs. mos. ds.

(Signed) J. R. Young M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: June 12 1920

20. UNDERTAKER: J. L. McClain ADDRESS: Pocatello

FORM C. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 24
File No. 31049
Registered No. 3356

1. PLACE OF DEATH
County of Bannock
City of Pocatello.
(No. Lynn Bro Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary J. Gallup

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: Aug (Month) 6 (Day) 1855 (Year)

7. AGE: 65 Yrs. 11 Mos. 8 da.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Jacob Coon

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R A Redfern
(Address) Missoula, Mont.

15. Filed 7-14 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8th 1920 to July 11th 1920
that I last saw her alive on July 11 1920,
and that death occurred on the date stated above, at 5:45a M.
The CAUSE OF DEATH* was as follows:
Cancer of the uterus

(Duration) Yrs. 9 mos. ds.
Contributory (Secondary) operation for old age
(Duration) yrs. mos. 3 ds.

(Signed) Dr Lynn M. D.
July 13 1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery. DATE OF BURIAL: 7/14 1920

20. UNDERTAKER: W W Walker ADDRESS: Pocatello Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
(No. Lyon Bros Hospital)

File No. 343105
Registered No. 3357

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cow Wallace

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	colored	Single

6. DATE OF BIRTH

..... 1 .....
(Month) (Day) (Year)

7. AGE

33 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer,

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) ~

10. NAME OF FATHER ~

11. BIRTHPLACE OF FATHER (State or Country) ~

12. MAIDEN NAME OF MOTHER ~

13. BIRTHPLACE OF MOTHER (State or Country) ~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Lyon

(Address) .....

15. Filed 7/14 1920. [signature] Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1920, to July 13 1920, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis Abscess

..... (Duration) Yrs. ..... mos. 11 ds.

Contributory (Secondary) Pneumonia Operation advised

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Lyon M. D.

July 13 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mt View Cemetery — DATE OF BURIAL 7/14 1920

20. UNDERTAKER [illegible] — ADDRESS Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 84
County of Bannock
Primary Registration District No. 2461
City of Pocatello (No.) St. Anthony Hospital
File No. 31051
Registered No. 3358
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Nancy B. Gabbert
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	Married

6. DATE OF BIRTH
May 27th 1872
(Month) (Day) (Year)

7. AGE
48 yrs. 1 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) U. S. A.

10. NAME OF FATHER D. L. Watson

11. BIRTHPLACE OF FATHER (State or Country) U. S. A.

12. MAIDEN NAME OF MOTHER Hannah Bond

13. BIRTHPLACE OF MOTHER (State or Country) U. S. A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Curtis Gabbert
(Address) Pocatello Star Route

15.
Filed 7/16-20 [illegible] J. F. Jump, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1920, to July 13 1920, that I last saw her alive on July 13 1920, and that death occurred on the date stated above, at 11:20 P.M.

The CAUSE OF DEATH* was as follows:
Exophthalmic goiter

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hamner C. Irwin M. D.
19 (Address) Pocatello Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: July 15 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31052

Registered No. 3359

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 241

(No. Lynn Bros Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl McDaniels

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Baby

6. DATE OF BIRTH: April (Month) 27 (Day) 1916 (Year)

7. AGE: 4 Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Miles City Mont.

10. NAME OF FATHER: A R McDaniels

11. BIRTHPLACE OF FATHER (State or Country): Tulsa Okla

12. MAIDEN NAME OF MOTHER: Ada Wengil

13. BIRTHPLACE OF MOTHER (State or Country): Pestico Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A R McDaniels.

(Address) 517 No 10.

15. Filed July 16 1920 Jas R Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16th 1920 to July 16th 1920 that I last saw ~~baby~~ alive on July 16th 1920 and that death occurred on the date stated above, at 2:45a M.

The CAUSE OF DEATH* was as follows: ~~Convulsions~~

Diarrhoea & Enteritis —

(Duration) ..... Yrs. ..... mos. 1/2 ds.

Contributory (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Lynn M. D.

July 16th 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 2 days.

Where was disease contracted if not at place of death?

Former or usual residence 517 N. 10th.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetary — DATE OF BURIAL: 7/17 1920

20. UNDERTAKER: Mrcraky — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
File No. 331453
Registered No. 3360

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. St. Anthonys Hosp)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles B. Fielger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (~~Write the word~~)

6. DATE OF BIRTH: May 14 1849 (Month) (Day) (Year)

7. AGE: 71 Yrs. 2 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cigar maker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Fielger

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Myller
(Address) 415 So. 5th ave.

15. Filed July 21 1920 J. M. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1920 to July 20 1920, that I last saw him alive on July 20 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Broken compensating Heart and myocarditis

(Duration) Yrs. 3 mos. ds.

Contributory (Secondary): None
(Duration) yrs. mos. ds.

(Signed) Asa Nunn M. D.
July 21 1920 (Address) Pocatello, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 30 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Cleveland Ohio

19. PLACE OF BURIAL OR REMOVAL: Cleveland Ohio | DATE OF BURIAL: July 23 1920

20. UNDERTAKER: H. L. McHan | ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31054
Registered No. 3361

Registration District No. 84
Primary Registration District No. 2161
(No. St. Anthonys Hosp St.)

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Fulmore Byrd
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: May (Month) 31 (Day) 1908 (Year)

7. AGE: 12 Yrs. 1 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: James F. Byrd

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Emma McClarkey

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James F. Byrd
(Address) 1055 So. 2nd ave

15. Filed July 17 1920
Jas Gunn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920, to July 16 1920, that I last saw h~~im~~ alive on July 16 1920, and that death occurred on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:
General peritonitis

..... (Duration) ..... Yrs. ..... mos. 24 ds.
Contributory (Secondary) Acute nephritis
..... (Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Am Newton M. D.
July 17 1920 (Address) Pocatello. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: July 18 20

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2461
File No. 31055
Registered No. 3362

1. PLACE OF DEATH.
County of Bannock
City of Pocatello
(No. 432 E. Hayden St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cresencia Villalpando
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	Mexican	Married

6. DATE OF BIRTH: Near as known 1896
(Month) (Day) (Year)

7. AGE: 24 yrs. mos. ds. (Exact date unknown)
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. Villalpando
(Address) 432 E. Hayden

15. Filed 7/19 1920 Fred Reed, Dep., Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 18 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1920 to July 19 1920 that I last saw h[illegible] alive on July 18 1920 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Confinement & with Post Partum Hemorrhage

(Duration) yrs. mos. ds.
Contributory (Secondary) adherent Placenta

(Duration) yrs. mos. ds.
(Signed) C. J. Baright M. D.
1920 (Address) 606 North Garfield

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: July 20 1920

20. UNDERTAKER: Johnson & Ray — ADDRESS: Pocatello

606 N Garfield

July

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 84

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33 1056

Registered No. 3363

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. 517 - No 4 ave, Rear St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francisco Viarro.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Did not Know (Month) (Day) 1881 (Year)

7. AGE: 39 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): San Felipe Mex.

10. NAME OF FATHER: Dorsano Viarra

11. BIRTHPLACE OF FATHER (State or Country): Mex

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (State or Country): Mex.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Daisy Evans - Undertaker
(Address) 202 - So 1. St.

15. Filed 7/20 19

J. H. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51668

7/20

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Gun Shot Br. Pedro Madura

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. D. Ferguson M. D.

7-20-1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Cemetery	7/20 19 20
20. UNDERTAKER	ADDRESS
Mumaker.	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3407

1. PLACE OF DEATH

County of Bannock — Registration District No. 84

City of Pocatello — Primary Registration District No. 2164

(No. 527 - East Bridge St.)

Registered No. 3364

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pedro Medina

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 22 (Month) (Day) 1884 (Year)

7. AGE: 36 Yrs. 7 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Pedro Medina

11. BIRTHPLACE OF FATHER (State or Country): Mex

12. MAIDEN NAME OF MOTHER: Jesus Olaso

13. BIRTHPLACE OF MOTHER (State or Country): Mex.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dawson Lewis Dog Inspector

(Address) 202 Pole Ave.

15. Filed 7/20 — 1920 — J. P. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun shot by Francisco Viarro

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. L. Ferguson M. D.

7-20-1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Cemetary	7/20 1920
20. UNDERTAKER	**ADDRESS**
Mr. Baker	Pocatello Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

7/20—

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31058
Registered No. 3365

1. PLACE OF DEATH.
County of Bannock
City Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 214
(No.) St. Anthony Hospital St.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dora Mary Melista

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Italian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct 29th 1899
(Month) (Day) (Year)

7. AGE: 20 yrs. 8 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Frank Grody

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Jenny Mariano

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul Melista
(Address) 222 N. 8th

15.
Filed July 21 1920 J. H. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July 19 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920, to July 19 1920
that I last saw her alive on July 19 1920,
and that death occurred on the date stated above, at 8:30 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Hemorrhage
(Duration) yrs. mos. 3 minutes ds.
Contributory Lung abscess
(Secondary)
(Duration) yrs. mos. 35 ds.

(Signed) Asa Merton M. D.
July 21 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View
DATE OF BURIAL: 7/21 1920

20. UNDERTAKER: Chamachan & Hood
ADDRESS: Pocatello Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 34059
Registered No. 33649

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 825 Washington St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME June Spencer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 29 (Day) 1918 (Year)

7. AGE: — Yrs. — Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: J. R. Spencer

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Ruby Horton

13. BIRTHPLACE OF MOTHER (State or Country): Creston Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ruby Horton July 20, 1920
(Address) 825 W. Washington ave

15. Filed July 21 1920 — J. W. Bowman, Local Registrar

SIMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 20 to July 22 1920, that I last saw h... alive on ... 19..., and that death occurred on the date stated above, at 5 A. M.
The CAUSE OF DEATH* was as follows:

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) John H. Bowman M. D.
July 22, 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View — DATE OF BURIAL: July 24 1920

20. UNDERTAKER: H. L. McClain — ADDRESS: Pocatello

Form No. 5 No. 22 m-10-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 18

County of Canyon

Primary Registration District No. 64

File No. 3367

City of Caldwell (No. 517 No. 10 St.) Registered No. 3367

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lydia Nellie McDaniel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 27 (Day) 1918 (Year)

7. AGE: 2 Yrs. 1 Mos. 23 ds. IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Nampa

10. NAME OF FATHER: A. R. McDaniel

11. BIRTHPLACE OF FATHER (State or Country): Tulsa Wash

12. MAIDEN NAME OF MOTHER: Ida Neuzil

13. BIRTHPLACE OF MOTHER (State or Country): Ohio Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. R. McDaniel
(Address) 517 No 10th

15. Filed July 21 1920 J. H. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1920 to July 20 1920 that I last saw her alive on July 20 1920, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:-
Acute gastritis

(Duration) Yrs. mos. ds.
Contributory (Secondary) Acute dilatation of heart.
(Duration) yrs. mos. ds.

(Signed) D. S. Ray M. D.
July 20 1920 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery | DATE OF BURIAL: July 21 1920

20. UNDERTAKER: Parker | ADDRESS: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

Dr Newton

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 31761
Registered No. 3368

1. PLACE OF DEATH.
County of Bannock
City of Pocatello (No. 505 S. 12th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Robbins
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed
6. DATE OF BIRTH: Oct 8th 1867 (Month) (Day) (Year)
7. AGE: 52 yrs. 9 mos. 16 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Missouri
10. NAME OF FATHER: James Robbins
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Emma Ann Williams
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Agnes M. Ward
(Address) 505 S. 12th
15. Filed 7/24 1920
J. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July 24 1920. (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 19 1920, to July 25 1920, that I last saw h er alive on July 25 1920, and that death occurred on the date stated above, at 3:45 a M.
The CAUSE OF DEATH* was as follows:
Acute nephritis and myocarditis
(Duration) yrs. mos. 5 ds.
Contributory (Secondary) Isolated pustules
(Duration) yrs. mos. 3 ds.
(Signed) Wm Newton M. D.
July 26 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View
DATE OF BURIAL: 7/26 1920
20. UNDERTAKER: Schumacher & Hall
ADDRESS: Pocatello
July

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84

Primary Registration District No. 2161

File No. 31063

Registered No. 3370

1. PLACE OF DEATH.

County of Bannock

City of Pocatello (No. N. Eighth St.) Hospital

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Angela Margaret O'Reilly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 22 (Day) 1897 (Year)

7. AGE: 23 yrs. 2 mos. 4 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello, Idaho

10. NAME OF FATHER: Mike O'Reilly

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Ellen Coffey

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mike O'Reilly
(Address) Pocatello Ida

15.
Filed 7/27 1920 J. A. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1920, to July 26 1920
that I last saw her alive on July 26 1920,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Acute nephritis and myocarditis

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary) Scarlet fever

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) A. M. Newton M. D.

July 27 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: July 29 1920

20. UNDERTAKER: Schumacher Bros — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 31164
Registered No. 3371

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 651 - So Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caleb Albert Pickett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: October 19 1888 (Month) (Day) (Year)

7. AGE: 31 Yrs. 9 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Salt Lake Utah.

10. NAME OF FATHER: John W Pickett

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Alice M Budd.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W Pickett
(Address) Logan Utah

15. Filed 7/28 1920

J M Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Pulmonary Hemorrhage following Epilepsy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Epilepsy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S S Ferguson Coroner M. D.

7-28 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah — DATE OF BURIAL: July 29 1920

20. UNDERTAKER: Shumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2141
File No. 31065
Registered No. 3372

1. PLACE OF DEATH

County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. At Batiste Springs St.) 6 miles N. W. of town

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Nelson Rowland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: May (Month) 17 (Day) 1856 (Year)

7. AGE: 64 Yrs. 2 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: Thomas Rowland

11. BIRTHPLACE OF FATHER (State or Country): Wales.

12. MAIDEN NAME OF MOTHER: Isabel Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louise C. Rowland
(Address) Pocatello, Idaho.

15. Filed July 31 1920 J. H. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1920, to July 29 1920, that I last saw h.im alive on July 29 1920, and that death occurred on the date stated above, at 12 40 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cirrhosis liver
Cholecystitis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Hamer C. Smith M. D.

July 31 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 28 yrs. ..... mos. ..... days. In the State 28 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Logan, Utah

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Aug 1 1920

20. UNDERTAKER: H. L. McKean — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31066

Registered No.

1. PLACE OF DEATH

County of Bannock

City of Bancroft

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. Bancroft Emergency Hospital. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Issac Grant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: January 30th (Month) 1890 (Day) (Year)

7. AGE: 30 Yrs. 4 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Chesterfield Idaho

10. NAME OF FATHER: Charles Albert Grant

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake City Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Anna Williams

13. BIRTHPLACE OF MOTHER (State or Country): Springville Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) signed. Eugene Ruger

(Address) Bnacroft Idaho

15. JUL 31 1926

Filed ..... 19 .....

O. V. Linkhart
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 4th (Month) (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25th 19 20 to June 4th 19 20 that I last saw him alive on June 4th 19 20 and that death occurred on the date stated above, at 4p M.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction-
following operation for Gastric ulcer,
posterior-gastro-enterostomy

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) surgical shock

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) ..... M. D.

6/5/ 19 20 (Address) Bnacroft Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 10 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Bancroft Idaho.

Former or usual residence Bnacroft Idaho.

19. PLACE OF BURIAL OR REMOVAL: Chesterfield Idaho

DATE OF BURIAL: 6/7/ 19 20

20. UNDERTAKER: Chris Call.

ADDRESS: Chesterfield Idah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53
Primary Registration District No. 2132
File No. 1121067
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Paris
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leonora L. Spencer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Married (Write the word.)

6. DATE OF BIRTH: January (Month) 16 (Day) 1849 (Year)

7. AGE: 71 Yrs. 4 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah, U.S.A.

10. NAME OF FATHER: Joseph Horne

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Isabelle Hale

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Spencer
(Address) Paris, Idaho

15. Filed 7/10/1920 F. J. Sutton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1920 to May 16 1920
that I last saw her alive on May 16 1920
and that death occurred on the date stated above, at 10:30 A.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia L L L
T L M L

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. J. Sutton M. D.
May 1 1920 (Address) Paris Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
City Cemetery, Paris, Ida.	May 19 1920
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bear Lake — Registration District No. 55

City of Paris — Primary Registration District No. 2132

(No. ..... St.)

File No. 113

Registered No. 31068

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Charles Perrett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 19 (Day) 1887 (Year)

7. AGE: 33 Yrs. 1 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Fireman

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George Perrett

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Coombs

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Perrett

(Address) Paris Idaho

15. Filed 7/10 1920 — R. J. Sutton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1920 to July 19 1920, that I last saw him alive on July 19 1920 and that death occured on the date stated above, at 11.40 A.M.

The CAUSE OF DEATH* was as follows: Shock from Accident, Pott's fracture, left, 3 severe lacerations tearing all muscles from post thigh & leg.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Moore M. D.

7/24 1920 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris — DATE OF BURIAL: May 21 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53
Primary Registration District No. 2132
(No. ..... St.)

File No. 11483 1069
Registered No. .....

1. PLACE OF DEATH

County of Bear Lake
City of Bloomington
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reginald Pattenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	white	Single (Write the word.)

6. DATE OF BIRTH: July (Month) 22 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. and ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bloomington Idaho.

10. NAME OF FATHER Joseph P. Pattenson

11. BIRTHPLACE OF FATHER (State or Country) Bloomington, Idaho

12. MAIDEN NAME OF MOTHER Elva Thornock

13. BIRTHPLACE OF MOTHER (State or Country) Bloomington, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J P Patterson
(Address) Bloomington, Idaho

15. Filed 7/11/ 1920 R. J. Sutton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1920, to July 22 1920
that I last saw h[illegible] alive on July 22 1920,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Edema of the Glottis
Pneumonia.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia Edema
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. E. Cushing M. D.
7-22 1920 (Address) Bloomington

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bloomington
DATE OF BURIAL: July 24 1920

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

B. No. 5-25 M. 1-16-13

PLACE OF DEATH.

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH.

Registration District No. 05

Primary Registration District No. 2136

(No. ..... St.)

2. FULL NAME David Hayes.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31070

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PH... should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact sta... of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 13 (Day) 1905 (Year)

7. AGE: 14 Yrs. 7 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John R. Hayes

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Harriet E. Deem

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Riley Hayes
(Address) Georgetown, Idaho.

15. Filed May 1st 1920 N. V. King Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1919, to Apr 1920, that I last saw him alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis
Valvular insufficiency
all valves affected

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) P. P. Gaylord, M. D.

April 1920 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Georgetown Idaho — DATE OF BURIAL: Apr 23 1920

20. UNDERTAKER: J. M. Williams — ADDRESS: Montpelier Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31071

Registered No.

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier. (No. ....., ... St.)

Registration District No. 52

Primary Registration District No. 2,36

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charlotte Ada, Nye.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 4 (Day) 1870 (Year)

7. AGE: 49 yrs. 7 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thos Croft.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Elyabeth Richardson

13. BIRTHPLACE OF MOTHER (State or Country): Eneyland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Nye
(Address) Montpelier, Idaho.

15. Filed Aug 1st 1920 — A. E. Kinney, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 18th 1920, to May 19th 1920 that I last saw her alive on May 19 1920, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Asthma + Myocarditis

(Duration) Several yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) E. F. Bryon M. D.

May 19 20 (Address) Montpelier Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris, Idaho. DATE OF BURIAL: May 22, 1920

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 31072
Registered No.

1. PLACE OF DEATH
County of Bear Lake Co
City of Raymond
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delbon Seldon Hart

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: August (Month) 23 (Day) 1914 (Year)

7. AGE: 5 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): none.

9. BIRTHPLACE (State or Country): Wyo. Lincoln Co.

10. NAME OF FATHER: L. R. Hart.

11. BIRTHPLACE OF FATHER (State or Country): Idaho Bear Lake Co.

12. MAIDEN NAME OF MOTHER: Ervine Evenson.

13. BIRTHPLACE OF MOTHER (State or Country): New Mexico Jackson Co.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. P. Hart
(Address) Raymond Idaho

15. Filed Aug 1, 1920 — H. K. Young, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 7th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1920 to June 7 1920 that I last saw h... alive on June 7 1920, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH was as follows:

Diphtheria

(Duration) Yrs. mos. 6 ds.
Contributory (Secondary) Broncho Pneumonia
(Duration) yrs. mos. 5 ds.

(Signed) J. P. Gardner M. D.
6/8 1920 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Raymond — DATE OF BURIAL: June 8 1920

20. UNDERTAKER: Bishop & Evans. — ADDRESS: Raymond Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136
(No. ....., ... St.)

File No. 31073
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carleon Linford Bryson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Dec. (Month) 7 (Day) 1895 (Year)

7. AGE
24 yrs. 6 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John S. Bryson.

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Belzora Linford

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John S Bryson
(Address) Fairview Wyo.

15. Filed Aug 1st 1920 — A. M. Kunz, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 18 1920, to 6-21 1920
that I last saw h alive on 6-21 1920
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Asphyxiation accidental

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Burns case

(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. Hudson, M. D.
6-22 1920 (Address) Cokeville, Wyo

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

Probable

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview Wyoming — DATE OF BURIAL: June 24 1920

20. UNDERTAKER: T. M. Williams — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31074

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 52

Primary Registration District No. 2136

County of Bear Lake.

City of Montpelier (No. ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver L Taggart.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 23 (Day) 1887 (Year)

7. AGE: 33 yrs. 5 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Hosea A. Taggart.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah M Livingston.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Taggart
(Address) Smoot Wyoming.

15. Filed 6/20 1920 W H Krug Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1920, to June 19 1920, that I last saw h— alive on June 19 1920, and that death occurred on the date stated above, at 12 P M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 6 yrs. mos. ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) H Beckus M. D.

6-20 1920 (Address) Montpelier.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Smoot Wyoming — DATE OF BURIAL: June 20 1920

20. UNDERTAKER: J. M. Williams — ADDRESS: Montpelier, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2136
File No. 31075
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oliver Douglas Holmes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: July 5th 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Montpelier Ida

10. NAME OF FATHER: Oliver W. Holmes

11. BIRTHPLACE OF FATHER (State or Country): Montpelier, Idaho

12. MAIDEN NAME OF MOTHER: Isabelle J. Hall

13. BIRTHPLACE OF MOTHER (State or Country): Bennington Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oliver W. Holmes
(Address) Montpelier Ida

15. Filed July 9th 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 7 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1920 to July 6 1920 that I last saw h— alive on July 6 1920 and that death occurred on the date stated above, at 3:00 P.M.
The CAUSE OF DEATH* was as follows: Premature Baby

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Heart Disease
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred S. Lindsley M. D.
July 9 1920 (Address) Bancroft Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bennington, Ida — DATE OF BURIAL: July 9 1920

20. UNDERTAKER: Wallace Mack — ADDRESS: Bennington

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 236
File No. 31076
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Bennington
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charlotte Perkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Single

6. DATE OF BIRTH April 10th 1919.
(Month) (Day) (Year)

7. AGE 1 Yrs. 3 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bennington, Ida.

10. NAME OF FATHER Wm. A. Perkins

11. BIRTHPLACE OF FATHER (State or Country) S. Lake City

12. MAIDEN NAME OF MOTHER Lottie Law

13. BIRTHPLACE OF MOTHER (State or Country) Paris, Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm A. Perkins
(Address) Soda Lake Idaho

15. Filed Aug 1, 1920 — W. K. Perry, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 8th 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1920, to July 8th 1920, that I last saw h.er alive on July 8th 1920, and that death occurred on the date stated above, at 3:30 P. M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elmer E. Hinckley M. D.
8-1-1920 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bennington Idaho	July 10 1920

20. UNDERTAKER Wallace Mercantile ADDRESS Bennington Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 31077
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Aegler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 13 (Day) 1877 (Year)

7. AGE: 43 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: John Aegler

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Mary Knutti

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Raymond Hirschi
(Address) Geneva Idaho

15. Filed Aug 1 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1920 to July 13 1920
that I last saw h.. alive on July 13 1920,
and that death occurred on the date stated above, at 8.9 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia following Cholecystotomy & Appendectomy
(Duration) Yrs. mos. 4 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) L P Gaertner M. D.
7/13 1920 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: July 15 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2,06

File No. 31078
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Verda Shumway

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White.	Single

6. DATE OF BIRTH
Jan (Month) 7 (Day) 1891 (Year)

7. AGE
29 yrs. 6 mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housework.
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Jackson Mexico

10. NAME OF FATHER Hyrum S. Shumway

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Anna Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Schmid
(Address) Bern Idaho

15.
Filed Aug 1 1920
N. K. Kinney
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5 1920 to July 14 1920 that I last saw h[illegible] alive on July 14 1920 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Septicemia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Cystic ovary
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo E Cudley M. D.
16 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bern Idaho. DATE OF BURIAL: July 16 1920

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31079
Registered No. ____
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bear Lake
City of St Charles
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 33
Primary Registration District No. 2332
(No. ____, ____ St.)

2. FULL NAME John Colin Stewart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: April (Month) 27 (Day) 1839 (Year)

7. AGE: 81 yrs. 3 mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming & Stock raising
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tuscaloosa Ala,

10. NAME OF FATHER: William Stewart

11. BIRTHPLACE OF FATHER (State or Country): dont know

12. MAIDEN NAME OF MOTHER: Delphia Jones

13. BIRTHPLACE OF MOTHER (State or Country): dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. Stewart (son of deceased)
(Address): St Charles, Idaho.

15.
Filed Aug 6 1920 John Matheson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) Wednesday (Day) 28th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 191__, to ____ 191__, that I last saw h____ alive on ____ 191__, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
No Doctor in attendance
Death due Heart failure

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory (Secondary)

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ M. D.

19__ (Address) ____

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles Id.
DATE OF BURIAL: July 30 1920

20. UNDERTAKER
ADDRESS

GYMS - YORK CO., PTRS. & BDRS. 19760

PLACE OF DEATH

County of Benewah

City or Town of Tensed

Washington State Board of Health

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No. 31081

Registered No. 9

Registration Dist. No. ..... No. ....., ...

(If death occurred in a hospital or institution, give its NAME instead of street and number)

2. FULL NAME Violet Elene Humphrey

(a) Residence No. ..... St.;

(Usual place of abode)

(b) If non-resident, give city or town, and state .....

(c) How long in Registration Dist. 4 yrs. 4 mos. 20 ds.; how long in U. S. if of foreign birth ..... yrs. ..... mos. ..... ds.

Personal and Statistical Particulars

3. Sex	4. Color or Race	5. Single, Married, Widowed or Divorced (Write the word)
F	W	Single

5. (a.) If married, widowed, or divorced:

Husband of .....

or

Wife of .....

6. Date of birth Feb 26 1916

(Month) (Day) (Year)

7. Age 4 yrs. 4 mos. 20 ds. If less than one day, hrs. ..... or min. .....

8. Occupation of deceased:

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9. Birthplace (City or town) Emmet Co

(State or country) Kansas

PARENTS

10. Name of Father Lee Humphreys

11. Birthplace of Father (City or town) (State or country) Kansas

12. Maiden name of Mother Rose Griffith

13. Birthplace of Mother (City or town) (State or country) Wash. Ritzville

14. Informant Lyle Humphreys

Address Tekoa Wash

15. Filed July 17, 1920 [illegible] Registrar.

Medical Certificate of Death

16. Date of death July 16 (Month) (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12, 1920, to July 16, 1920, that I last saw her alive on July 16, 1920, and that death occurred on the date stated above, at 5 P m. (State the disease causing death, or, in deaths from violent causes, state: (1) Means and nature of injury; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL). (OVER)

The CAUSE OF DEATH was as follows:

Cerebro Spinal Meningitis

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at the place of death? .....

(a) Did an operation precede death? No Date of -

(b) Was there an autopsy? No

(c) What test confirmed diagnosis? Spinal fluid

(Signed) Dr L B Gates M. D.

7/17, 1920 Address Tekoa

19. Place of Burial, Cremation or Removal Medical Lake Wash | Date of Burial 7/18, 1920

20. Undertaker C. C. Schulerud | Address Tekoa Wash

I HEREBY CERTIFY, That I have made the effort but was unable to secure answers to questions .....

(Insert numbers of unanswered questions) (Signature of Undertaker)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1—25M-4-4-19

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No.
File No. 31082
Registered No. 17

1. PLACE OF DEATH
County of Bannock
City of Dr Dennet
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (Unnamed) Lyden
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Infant

6. DATE OF BIRTH: July 1st 1920 (Month) (Day) (Year)

7. AGE: ... Yrs. ... Mos. 5 hours ds.
IF LESS than 1 day how many 5 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hospital at Dr Dennet, Idaho

10. NAME OF FATHER: Fred Lyden

11. BIRTHPLACE OF FATHER (State or Country): Kans.

12. MAIDEN NAME OF MOTHER: Beathel May

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Lyden
(Address) Downet, Idaho

15. Filed July 3 1920
J. de Bikram
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 2nd 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920 to July 2 1920 that I last saw h~~im~~ alive on July 1 1920 and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* ~~was~~ as follows: Prematurity Birth

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) J. A. Nelson M. D.
19... (Address) Declo, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dennet Idaho	July 3 1920
20. UNDERTAKER J. Falcon	ADDRESS Dennet

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 1 31083
Registered No. 18

1. PLACE OF DEATH.
County of Bonneville
City of Desmet
(No. ....., ... St.)
Registration District No 31
Primary Registration District No .....
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James V Sanderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 60 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Not known

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mc Phee
(Address) Farmington Wash

15.
Filed July 12 1912
J. L. Beham
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 10 1912 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Heart disease.
Coma
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W. L. Glenn (Coroner) M. D.
19..... (Address) St Maries, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Tekoa Wash. DATE OF BURIAL: 7/13 1912

20. UNDERTAKER: C. L. Schulerud ADDRESS: Tekoa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FOR [redacted]-26 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. [redacted]CE OF DEATH.

Registration District No. 31

File No. 131084

County of Benewah

Primary Registration District No.

Registered No. 19

City of Tensed

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Violet Edna Humphreys

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Feb (Month) 26 (Day) 1916 (Year)

7. AGE: 4 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Benewah Co

10. NAME OF FATHER: Lesle Humphrey

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Pearl Guffab

13. BIRTHPLACE OF MOTHER (State or Country): Ritzville Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lesle Humphrey

(Address) Tekoa, Wash

15.

Filed July 17 1920

J. Le Bilan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1920, to July 16 1920, that I last saw her alive on July 16 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal meningitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Dr. C. B. Clizer M. D.

19..... (Address) Tekoa Wn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Medical Lake Wn	7/18 1920
20. UNDERTAKER	**ADDRESS**
C. L. Schuleand	Tekoa Wn

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 3108
Registered No. 38

1. PLACE OF DEATH
County of Benewah
City of Tensed
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Aug 2 1920 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Body found Aug 1 1920
..... (Month) ..... (Day) 19 ..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19 ....., to ..... 19 .....,
that I last saw h..... alive on ..... 19 .....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Skeleton found in Slough Aug 1st 1920 one mile East of Tensed Ida. Identification impossible
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H L Alcorn Coroner of Benewah Co. M. D.
Aug 2 1920 (Address) St Maries Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Woodlawn | DATE OF BURIAL 8 2 1920

20. UNDERTAKER H E Hunt Co | ADDRESS St Maries

PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
...tem of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH ...ns, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Benewah — Registration District No. 32

City of St Maries — Primary Registration District No. 2049

(No. ..... , ... St.)

File No. 3108

Registered No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Soishi Inyesvo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1900 (Year)

7. AGE: 19 Yrs. 7 Mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laundry
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: Sozaburo Inyesvo

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Yume Takahashi

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sozaburo Inyesvo
(Address) St Maries

15. Filed July 24 1920 — H E Smith, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1 1920, to July 24 1920, that I last saw him alive on June 21 1920, and that death occurred on the date stated above, at 4A. M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of the Lungs
(Duration) Yrs. 6 mos. ..... ds.
Contributory (Secondary) Tuberculous Enteritis
(Duration) Yrs. 3 mos. ..... ds.
(Signed) C. A. Robins M. D.
July 24 1920 (Address) St. Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2Y yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Unknown
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene Wash. — DATE OF BURIAL: 7-25-1920

20. UNDERTAKER: H E Smith Co — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31087

Registration District No. 32

Primary Registration District No. 2049

Registered No. 36

1. PLACE OF DEATH

County of Benewah

City of St. Maries Ida (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Sullivan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	single

6. DATE OF BIRTH: About (Month) (Day) 1880 (Year)

7. AGE: 40 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lumberman

(b) General nature of industry, business or establishment in which employed (or employer): Loader

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas. McBride

(Address) St Maries Ida.

15. Filed July 24 1920 H E Hunt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1920 to July 22 1920 that I last saw him alive on July 22 1920 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Chronic alcholism

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O O Plail M. D.

July 23 1920 (Address) St Maries, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	7/24 1920

20. UNDERTAKER	ADDRESS
Mitchell & Meager	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 31088
Registered No. 35

1. PLACE OF DEATH
County of Bonneville
City of St. Maries
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hank Maloney
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE: About 68 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed July 21 1920 — H E Hunt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1920 to July 20 1920, that I last saw h[illegible] alive on July 20 1920, and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [signature] M. D.
7/21 1920 (Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 7/21 1920

20. UNDERTAKER: H E Hunt Co — ADDRESS: St Maries

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31090

Registered No. 33

1. PLACE OF DEATH.

County of Bonneville

City of St Maries

Registration District No. 32

Primary Registration District No. 2049

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erma Constance Gregg.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 29 (Day) 1899 (Year)

7. AGE: 21 Yrs. 1 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Minn.

10. NAME OF FATHER Ernest M. Warren

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Ella M Jahraus

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E M Warren

(Address) St Maries

15. Filed July 19 1920

H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h...alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Instantly Killed in automobile Accident

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration .....yrs.....mos.....ds.

(Signed) H. L. Alcorn, Coroner ~~M. D.~~ Bonneville Co.

7/19 1920 (Address) St Maries Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	July 22 1920
20. UNDERTAKER	**ADDRESS**
H E Hunt Co	St M.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31691

Registered No. 32

1. PLACE OF DEATH.

County of Bonneville

City of Emerald Creek (No. ..... St.)

Registration District No. 32

Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unknown man

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... 1 ..... (Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work. No

(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

Information caused by obtained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed July 17 1920. H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec 1 (Month) Known (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191....., to ..... 191.....,

that I last saw h..... alive on ..... 191.....,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:,

Un Known - Every indication

Above Foul Play.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

July 14 1920 (Signed) H. L. Alcorn Coroner M. D.

(Address) of Bonneville Co. Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wood Lawn | DATE OF BURIAL 7/18 1920

20. UNDERTAKER H E Hunt Co. | ADDRESS St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - [illegible] CO., PTRS. & ENGS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 39

Primary Registration District No. 2049

File No. 31093

Registered No. 30

County of Benewah

City of Santa (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ezra Lawson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: June (Month) 11th (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 4 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nona
(b) General nature of industry, business or establishment in which employed (or employer): Santa, Idaho

9. BIRTHPLACE (State or Country): Tyson Creek Idaho

10. NAME OF FATHER: Geo Lawson

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Mary McCannon

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Geo Lawson
(Address): Tyson Creek, Idaho

15. Filed July 16 1920 H E Hurst
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15th (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1920, to July 15 1920, that I last saw her alive on July 14 1920, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Malnutrition.

(Duration) Yrs. mos. ds.

Contributory (Secondary): Premature birth

(Duration) yrs. mos. ds.

(Signed) J. L. Swarbrick M. D.

7/16 1920 (Address) St. Maries Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Santa Ida | DATE OF BURIAL: July 19 20

20. UNDERTAKER: Mitchell & Mesenger | ADDRESS: St Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... St.)

File No. 31094
Registered No. 29

1. PLACE OF DEATH.
County of Benewah
City of St. Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	single

6. DATE OF BIRTH.
Oct (Month) 19 (Day) 1898 (Year)

7. AGE
27 Yrs. 9 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Bridge carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)... C. M. & St. P. R. R.

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) Italy.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Identification Card
(Address) Pass port record.

15.
Filed July 6 1920
H E Lust
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1920 to June 19 1920, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Falling from R. R. Bridge into St. Marie River caused broken neck. Deceased subject to epileptic fits
(Duration) ..... Yrs. ..... mos. Instantly ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H Malcom { Coroner Benewah Co.
June 20 1920 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	July 7 1920

20. UNDERTAKER	ADDRESS
Mitchell & Meager	St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRON - WEBER CO., PTGS. & ENGS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 215
File No. 31805
Registered No. 93

1. PLACE OF DEATH.
County of Bingham
City of Sterling
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rulon Lamar Shaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct 5 (Month) (Day) 1901 (Year)

7. AGE: 18 Yrs. 8 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: James F. Shaw

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Fanny Ellen Broadbent

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. F. Shaw
(Address) Sterling Idaho

15. Filed July 1 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1919 to June 27 1920 that I last saw h[illegible] alive on June 6 1920 and that death occured on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:
Sarcoma of Tibia

(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Secondary Sarcomata of skull and lungs
(Duration yrs. 4 mos. ds.

(Signed) W. C. Watkins M. D.
7/1 1920 (Address) Aberdeen Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Springfield Idaho — DATE OF BURIAL: 6/28 1920

20. UNDERTAKER: Friends — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 31096
Registered No. 478

1. PLACE OF DEATH
County of Bingham
City of Midland Power (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Price Miller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1865 (Year)

7. AGE: 54 Yrs. 8 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: James Miller

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Hannah Dr Wolf

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Fred P Miller
(Address) Midland Idaho

15. Filed July 6 19 20 Mrs N. E. Patrie Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Immediately July 3
that I last saw h..... alive on 1920
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Drowned - Suicidal
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Progressive Spinal Paralysis
..... (Duration) 1 yrs. ..... mos. ..... ds.
(Signed) E J Peck coroner M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fern Ck cemetery | DATE OF BURIAL: 7-2-1920

20. UNDERTAKER: E J Peck | ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE, IDAHO

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121.
Primary Registration District No. 2194.
(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31097
Registered No. 79

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bingham
City of Blackfoat
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Merle Edwin Pea

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Jan (Month) 29 (Day) 1919 (Year)

7. AGE: 1 Yrs. 5 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Miles Albert Pea

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Minnie Ralph

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miles Albert Pea
(Address) Pingree Idaho

15. Filed July 7 1920 Mrs N. E. Patrie
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30 1920 to July 6 1920
that I last saw him alive on July 6 1920
and that death occurred on the date stated above, at 4:20 P.M.
The CAUSE OF DEATH* was as follows:
Septicemia

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Humphreys M. D.
7/7 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Thomas. DATE OF BURIAL: 7-8 1920
20. UNDERTAKER: E J Funk ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 121

Primary Registration District No. [illegible]

File No. 31098

County of Bingham

City of Blackfoot (No. Apple addition St.)

Registered No. 80

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 25 (Day) 1846 (Year)

7. AGE: 85 Yrs. 0 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Wm Scott

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Anna — ?

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Martha Dawson

(Address) Blackfoot Idaho

15. Filed July 10 1920 Mo. N. E. Pat[illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1920 to July 10 1920, that I last saw h[illegible] alive on July 9 1920 and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Paralysis - Progressive

Apnea

(Duration) 30 Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) M. E. Pat[illegible] M. D.

July 19 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fem City Cemetery — DATE OF BURIAL: 7/12 1920

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 31099
Registered No. 81

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Stander

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 3 hours July (Month) 11 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Blackfoot Ida.

10. NAME OF FATHER: Ralph Stander

11. BIRTHPLACE OF FATHER (State or Country): Blackfoot Ida.

12. MAIDEN NAME OF MOTHER: Margaret Kraus

13. BIRTHPLACE OF MOTHER (State or Country): Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ralph Stander
(Address) Blackfoot Idaho

15. Filed July 12 1920 M. Nalen E. Patrick
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11th 1920 to ..... 19.....
that I last saw h.. alive on July 11 1920
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Premature Baby less than 7 mos. Born at 4 o'clock & died at 7 P.M.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) 3 hrs.
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. O. Hamilton M. D.
7/12/1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Russell — DATE OF BURIAL: 7-12 1920

20. UNDERTAKER: Ralph Stander acting — ADDRESS: Thomas

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 31160
Registered No. 82

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Hone
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 11 (Day) 871 (Year)

7. AGE: 49 Yrs. 2 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lancashire England

10. NAME OF FATHER: Caleb Hone

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Alice Taylor

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Amelia Hone
(Address) Wapello

15. Filed July 16 1920 Mrs. V. E. Parris Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 2 1920 to July 16 1920 that I last saw h[illegible] alive on July 16 1920 and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:

[illegible] Bright's disease

(Duration) Yrs. 2 mos. 14 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Metcalf M. D.
7/16 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery — DATE OF BURIAL: July 18 1920

20. UNDERTAKER: Ed L. Egli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 721

Primary Registration District No. 1007

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31102

Registered No. 84

1. **PLACE OF DEATH**

County of Bingham

City of Blackfoot

(No. Vault Mystic St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** John E. Shannon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. **DATE OF BIRTH** Nov (Month) 6 (Day) 1843 (Year)

7. **AGE** 76 Yrs. Mos. 8 ds. 18

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Penn.

10. **NAME OF FATHER** John Shannon

11. **BIRTHPLACE OF FATHER** (State or Country) Unknown

12. **MAIDEN NAME OF MOTHER** Unknown

13. **BIRTHPLACE OF MOTHER** (State or Country) Unknown

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) William Swigart

(Address) Black-foot Ida

15. Filed July 26 1920 Mo H. E Patrick
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1919 to July 24 1920 that I last saw h.. alive on July 23 1920 and that death occurred on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:

Chronic pneumonia phthisis

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) J O Hamilton M. D.

7/24 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sylvan Lawn Kansas	19 .....
20. UNDERTAKER	**ADDRESS**
E. S. Peck	Blackfoot Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1907
File No. 31103
Registered No. 85

1. PLACE OF DEATH

County of Bingham
City of Blackfoot
(No. 22 Commons Hospital St.)
Ward Judicial District

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucy Anna Fackrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Single

6. DATE OF BIRTH: May (Month) 29 (Day) 1915 (Year)

7. AGE: 5 Yrs. 1 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bingham Co Idaho

10. NAME OF FATHER: P. P. Fackrell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lucy Williams

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P. P. Fackrell
(Address)

15. Filed July 25 1920 Mrs. A. E. Patrick Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1920 to July 25 1920 that I last saw her alive on July 25 1920 and that death occurred on the date stated above, at 4½ 30 M.

The CAUSE OF DEATH* was as follows:
Shock following Severe Burn of Legs & abdomen & back.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) 3rd Degree Burns
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Simmons M. D.
7/25 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Rupert — DATE OF BURIAL: 7-26 1920

20. UNDERTAKER: E. J. Funk — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31104
Registered No. 86

Registration District No. 121
Primary Registration District No. 2196
(No. .... St.)

1. PLACE OF DEATH.
County of Bingham
City of Pingree
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hans S. Keughley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Co.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Feb. 6 (Month) (Day) 1848 (Year)
7. AGE 64 Yrs. 5 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Idaho
10. NAME OF FATHER Willis Keughley
11. BIRTHPLACE OF FATHER (State or Country) Utah
12. MAIDEN NAME OF MOTHER Carrie Hansen
13. BIRTHPLACE OF MOTHER (State or Country) Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. L. Higley
(Address) Blackfoot
15. Filed July 30 1928 Mo. M. E. Patrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 29 (Day) 1928 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 23 1928, to July 29 1928, that I last saw him alive on July 30 1928, and that death occured on the date stated above, at 5:20 P. M.
The CAUSE OF DEATH* was as follows:
Influenza Pneumonia Bronchial
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) J. W. Beck M. D.
(Address) Shelley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grim Cemetery — DATE OF BURIAL: July 31 1928
20. UNDERTAKER: E T Peck — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No.
File No. 331105
Registered No. 3

1. PLACE OF DEATH
County of Boise
City of Quartzburg (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary J Harrison
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: Aug (Month) 7 (Day) 1850 (Year)

7. AGE: 69 Yrs. 11 Mos. 24 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: William Conner

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Margaret Harkison

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C W Harrison
(Address) Quartzburg Ida

15. Filed Aug 1 1920 Mrs. J. J. Evans, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920 to Aug 1 1920, that I last saw h.e. alive on July 31 1920, and that death occurred on the date stated above, at 330 A.M.

The CAUSE OF DEATH* was as follows:
Nephritis
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) G E Stiff M. D.
Aug 1 1920 (Address) Quartzburg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise Idaho	Aug 3 1920

20. UNDERTAKER	ADDRESS
Summers & Wells	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
(No. ..... St.)

File No. 31106
Registered No. 31

1. PLACE OF DEATH.
County of Blaine
City of Ketchum

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert Norman Winslow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White.	Single.

6. DATE OF BIRTH. March (Month) 10th (Day) 1920 (Year)

7. AGE ....0.... Yrs. ....3.... Mos. ..21.... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Twin Falls Ida.

10. NAME OF FATHER Arthur J Winslow

11. BIRTHPLACE OF FATHER (State or Country) Ind.

12. MAIDEN NAME OF MOTHER Anna Holland

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A J Winslow
(Address) Ketchum Ida.

15. Filed 6-30 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 30th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1920, to June 1920, that I last saw him alive on June 25 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebrospinal Meningitis

(Duration) ..... Yrs. 1 mos. 20 ds.
Contributory (Secondary) Intestinal Intoxication
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. D. Parrott M.D.
7-1-1920 (Address) Hailey, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ketchum Ida	7/1 1920
20. UNDERTAKER R. D. Harris	ADDRESS Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No. 2022
(No. ....., ... St.)

File No. 31107
Registered No. 32

1. PLACE OF DEATH.
County of Blaine.
City of Bellevue.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Howard Rockwell.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.
6. DATE OF BIRTH. March 30. 1914
(Month) (Day) (Year)
7. AGE: 6 Yrs. 2 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: C
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho.
10. NAME OF FATHER: J. E. Rockwell.
11. BIRTHPLACE OF FATHER (State or Country): Wisconsin.
12. MAIDEN NAME OF MOTHER: L. P. White.
13. BIRTHPLACE OF MOTHER (State or Country): Iowa.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. E. Rockwell
(Address) Bellevue Ida.
15. Filed Aug-1 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH

Planned.

16. DATE OF DEATH: June 27 1920
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 27 1920 to — 191....., that I last saw him alive on — 191....., and that death occured on the date stated above, at 6:30 P M.
The CAUSE OF DEATH* was as follows:
Drowning
(Duration) — Yrs. — mos. ..... ds.
Contributory (Secondary) —
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. J. Russell M. D.
19..... (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellevue. DATE OF BURIAL: June 29. 1920.
20. UNDERTAKER: J. S. Harris. ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31108

Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Blaine

City of Carey

(No. ....., ... St.)

Registration District No. 21

Primary Registration District No. 2075

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Adamson

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. Nov. (Month) 25 (Day) 1879 (Year)

7. AGE: 41 Yrs. 7 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer)..... Mer. Business

9. BIRTHPLACE (State or Country) Heber Utah

10. NAME OF FATHER John Adamson

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Margaret Murdoch

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. Adamson.
(Address) Carey Idaho.

15. Filed Aug 1 1920 R. H. Wright Local Registrar

SYMS - YORK CO., PTRS. & STNRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1919, to July 7 1920, that I last saw h.. alive on July 7 1920 and that death occured on the date stated above, at 5:10 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Abscess

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) Endo carditis

(Duration ..... yrs. 8 mos. ..... ds.

(Signed) Houston E Snyder M. D.

7-12-1920 (Address) Carey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Carey, Ida. DATE OF BURIAL: 7-9 1920

20. UNDERTAKER: R. D. Harris ADDRESS: Hailey

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 21

Primary Registration District No. 2022

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31109

Registered No. 34

1. **PLACE OF DEATH.**

County of Blaine.

City of Hailey,

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Grace Lilian Eastwood.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED.** (Write the word.) Married.

6. **DATE OF BIRTH.** Sept. 11th 1894.
(Month) (Day) (Year)

7. **AGE** 25 Yrs. 10 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work... Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. **BIRTHPLACE** (State or Country) Idaho.

10. **NAME OF FATHER** Neal C. Heath.

11. **BIRTHPLACE OF FATHER** (State or Country) Kansas.

12. **MAIDEN NAME OF MOTHER** Nettie Aulger.

13. **BIRTHPLACE OF MOTHER** (State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.**

(Informant) x E. J. Eastwood

(Address) Hailey, Idaho.

15.

Filed Aug-1 1920 R. H. Wright
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

Wright.

16. **DATE OF DEATH** July 19, 1920.
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** July, 16 1920 **to** July, 19 1920 **that I last saw h** ex **alive on** July, 19 1920 **and that death occured on the date stated above, at** 12:10 M.

The CAUSE OF DEATH* was as follows:

Septicemia

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.

7-20 1920 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Hailey Idaho. **DATE OF BURIAL** 7-21 1920

20. **UNDERTAKER** R. H. Wright. **ADDRESS** Hailey

Form 860—5-M-4-19

SPOKANE HEALTH DEPARTMENT AND BUREAU OF VITAL STATISTICS

31110

City of Spokane
Registration District No. 2

DEATH CERTIFICATE

Record No. 5795

1. PLACE OF DEATH No. Near Sandpoint, Idaho St. Registered No.
(If death occurred in a hospital or institution, give its name instead of St. and No.)

2. FULL NAME Virgil Lee

(a) Residence No. (Usual place of abode) St.; Section of Spokane—East; West; North; South; (Encircle Section)

(b) If non-resident, give city or town, and state Mabton, Wash.

(c) How long in Spokane yrs. mos. ds.; how long in U. S. if of foreign birth yrs. mos. ds.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of DISEASE is very important. See instructions on back of certificate. should state CAUSE OF DEATH in plain terms, so that it may be properly classified.

Personal and Statistical Particulars.

3. Sex	4. Color or Race	5. Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5. (a) If married, widowed, or divorced
Husband of Rebecca Lee
or
Wife of

6. Date of birth: May (Month) 13 (Day) 1854 (Year)

7. Age: 66 yrs 2 mos 19 ds. If less than one day: hrs or min.

8. Occupation of deceased:
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9. Birthplace (City or Town)
(State or country) Ohio

10. Name of Father: James Lee
Birthplace of Father (City or Town) (State or Country) Not obt.

12. Maiden Name of Mother: Marie Nash
(City or Town) (State or Country) Not obt.

Informant: Rebecca Lee
Address: Mabton, Wash.

Filed 1920
AUG 4
SPOKANE, WASH.

16. Filed: Registrar
191: By Deputy.

Medical Certificate of Death.

16. Date of death: Aug. 4, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from , 191 , to , 191 , that I last saw h alive on about 191 , and that death occurred on the date stated above, at 6:00AM m.
(State the Disease causing Death, or, in deaths from Violent causes, state: (1) Means and nature of Injury; and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL)
The CAUSE OF DEATH was as follows:

Chronic Myocarditis and Endocarditis

(Duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(Duration) yrs. mos. ds.

18. Where was disease contracted if not at the place of death?
(a) Did an operation precede death? No Date of
(b) Was there an autopsy? No
(c) What test confirmed diagnosis? Information from Dr. McCormack Mabton, Wn.

(Signed) W. H. Neuma M. D.
8/4, 1920. Address Coroner

19. Place of Burial, Cremation or Removal: Mabton, Wash. Date of Burial: Aug. 4, 1920

20. Undertaker: SMITH & CO. Address

I HEREBY CERTIFY, That I have been unable to secure answers to questions
(Insert numbers of unanswered questions)

(Signature of Undertaker)

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of [redacted]

City of Dover

Registration District No. 78

Primary Registration District No. 2173-1

(Village) Dover. St.)

File No. 31111

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. J. Mossburg.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Unknown (Month) (Day) 1858. (Year)

7. AGE: 62 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laberer
(b) General nature of industry, business or establishment in which employed (or employer): in Woods.

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: ------ Mossburg.

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Billie Mossburg.
(Address) Dover, Ida.

15. Filed July 8 1920

FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 30, (Day) 20. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920 to June 30 1920
that I last saw him alive on June 19
and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:
Did not see patient until after death. Cause Apoplexy
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Floyd Wendle M. D.
July, 19 20. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: July, 2, 1920.

20. UNDERTAKER: B.W.PUGH. ADDRESS: SANDPOINT. IDA.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 3116
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint
(No. City Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm S. Conklin.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June 29 1875
(Month) (Day) (Year)

7. AGE: 45 Yrs. 4 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer): Active Farmer.

9. BIRTHPLACE (State or Country): [illegible]

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country): [illegible]

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) MRS. STEPHEN DADD.
(Address) IONIA. MICH.

15. Filed Aug 12 1920

FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July-30 1920, to July-30 1920, that I last saw him alive on July-30 1920, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Traumatic injury to head

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Floyd Wendle M. D.

Aug. 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. I days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: SANDPOINT. IDA.

DATE OF BURIAL: AUG. 12. 1920

20. UNDERTAKER: B. W. Rugh,

ADDRESS: SANDPOINT. IDA.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31113

Registered No. .....

1. PLACE OF DEATH.

County of Bonner

City of Laclede, Ida

(No. Laclede, Ida. St.)

Registration District No. 78

Primary Registration District No. 2155

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jesse E. Haines

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. July (Month) 13 (Day) 1892 (Year)

7. AGE: 28 Yrs. 0 Mos. 20 ds.

IF LESS than 1 day how many ..X.. hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: Walter E. Haines

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary McPerkins

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter Haines

(Address) Laclede, Idaho

15. Filed Aug 8 1920

FLOYD G. WENDLE
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to Aug 2 1920, that I last saw him alive on Aug 2 1920 and that death occured on the date stated above, at 11 o'clock A.M.

The CAUSE OF DEATH* was as follows: Drowning accidental

.....

.....

X X (Duration) X X Yrs. X X mos. X X ds.

Contributory (Secondary) .....

X X (Duration X X yrs. X X mos. X X ds.

(Signed) F. W. Sadler M. D.

Aug 3 1920 (Address) Laclede Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....Colburn, Ida.....

19. PLACE OF BURIAL OR REMOVAL: Colburn Idaho — DATE OF BURIAL: Aug 4 1920

20. UNDERTAKER: D. F. Engle — ADDRESS: Sandpoint, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31114

Registered No.

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

Registration District No. 7D

Primary Registration District No. 2155

(No. City Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Vought

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Mar, 10, 1831 (Month) (Day) (Year)

7. AGE: 89 Yrs. 3 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cruiser

(b) General nature of industry, business or establishment in which employed (or employer): in Woods

9. BIRTHPLACE (State or Country): Penna.

10. NAME OF FATHER: Thos Vought.

11. BIRTHPLACE OF FATHER (State or Country): Penna.

12. MAIDEN NAME OF MOTHER: Luey --- Neffaw.

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Oliver D. Hailman.

(Address) Sagle, Ida.

15. Filed Aug 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June, 21, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1920 to June 21 1920 that I last saw him alive on June 21 1920 and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Prostatitis, Chronic

(Duration) 30 (?) Yrs. mos. ds.

Contributory (Secondary) Prostatitis, Acute

(Duration) yrs. mos. 15 ds.

(Signed) C. P. Stackhouse M. D.

June 26 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 14 days. In the State 15 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Sagle, Ida.

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: June, 23, 1920

20. UNDERTAKER: B.W. Pugh. ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 2 1 7 7

(No. Culver Spur, Ida. St.)

File No. 31115

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Venovich.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 6 1870 (Month) (Day) (Year)

7. AGE: 50 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer. (Active.)

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria.

10. NAME OF FATHER: John Venovich.

11. BIRTHPLACE OF FATHER (State or Country): Austria.

12. MAIDEN NAME OF MOTHER: Soka Obradovic.

13. BIRTHPLACE OF MOTHER (State or Country): Austria.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Chas Reeves.

(Address) Sandpoint, Ida.

15. Filed July 9 1920

FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July, 7, 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19... to ... 19...

that I last saw h... alive on July 7 1920

and that death occurred on the date stated above, at 9:00 A.M. P.

The CAUSE OF DEATH* was as follows: Fracture compound right temporal & two penetrating wounds right & left occipital region caused by horse & cart. (Duration) ... Yrs. ... mos. during runaway. Instant.

Contributory (Secondary) ...

... (Duration) ... yrs. ... mos. ... ds.

(Signed) O. A. Page M. D.

July 9, 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: SANDPOINT. IDA.

DATE OF BURIAL: JULY 9 1920.

20. UNDERTAKER: B. W. PUGH.

ADDRESS: SANDPOINT. IDA.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 42
File No. 31116
Registered No. 116

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. Peoples Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hannah Elizabeth Landen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 16 (Day) 1887 (Year)

7. AGE: 38 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William Pulsipher

11. BIRTHPLACE OF FATHER (State or Country): Illenois

12. MAIDEN NAME OF MOTHER: Miranda Mikesell

13. BIRTHPLACE OF MOTHER (State or Country): Illenois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John F. Landen
(Address) Firth Idaho

15. Filed Aug 6 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1920, to Aug 4 1920
that I last saw h[er] alive on Aug 4 1920
and that death occurred on the date stated above, at 3:50 P. M.
The CAUSE OF DEATH* was as follows:
Uremic Convulsions
Acute Nephritis
(Duration) 1 Yrs. mos. 1 ds.
Contributory (Secondary) Nephritis - pyo-nephritis
(Duration) 10 yrs. mos. ds.
(Signed) H. D. Jenkins M. D.
Aug 7 1920 (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Firth Idaho — DATE OF BURIAL: Aug 7 1920

20. UNDERTAKER: Taylor-Kleaver Mtd — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31117
Registered No. 11

1. PLACE OF DEATH
County of Bonneville
City of New Sweden
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73
Primary Registration District No. 7201-0

2. FULL NAME Infant Sleffy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 28 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many 3 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Charles Sleffy

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: May Snively

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Sleffy
(Address) Idaho Falls

15. Filed Aug 7 1920 C. E. Turner Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1920, to July 28 1920, that I last saw h. in alive on July 28 1920, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

A Blue Baby, lived 3 hrs—

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. L. Wilson M. D.

8/4 1920 (Address) Idaho Falls, Ida—

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? —

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: July 29 1920

20. UNDERTAKER: Taylor-Ellerson Undt. ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21-0
File No. 31118
Registered No. 114

1. PLACE OF DEATH
County of Bonneville
City Ida Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: June 5th 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls Ida

10. NAME OF FATHER: Melvin L. Johnson

11. BIRTHPLACE OF FATHER (State or Country): Wyoming

12. MAIDEN NAME OF MOTHER: Mar Ella Daniels

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Melvin L. Johnson
(Address) Idaho Falls Ida.

15. Filed July 24 1920 W. W. Kennard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 17 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1920, to June 17 1920 that I last saw h.. alive on June 17 1920, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Aspiration Pneumonia

..... (Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Very weak & small baby

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. L. Wilson M. D.
7/23 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ida Falls — DATE OF BURIAL: 6/14 1920

20. UNDERTAKER: C C Dunwoody — ADDRESS: Ida Falls

A. L. Wilson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 N 0
File No. 31119
Registered No. 773

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Ann Hardy
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 5 (Day) 88 (Year)

7. AGE: 31 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Charles Myler

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Isabelle Martin

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Hardy
(Address) R D 3, Idaho Falls

15. Filed July 26 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 1920, to May 13 1920 that I last saw h[illegible] alive on May 13 1920 and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:
Puerperal Septicemia

(Duration) ..... Yrs. ..... mos. 32 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
July 26 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Taylor, Ida — DATE OF BURIAL: 5/26 1920

20. UNDERTAKER: E E Lemmon — ADDRESS: Ida Falls

Dr Spencer

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21 J-0
File No. 31120
Registered No. 112

1. PLACE OF DEATH
County of Jennille
City of Ida Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Nash
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 1 (Day) 1901 (Year)

7. AGE: 19 Yrs. 1 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: R H Nash

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rosalia Hoderlie

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R H Nash
(Address) Sugar City Ida

15. Filed July 24 1920 Lora Timmins Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
"Criminal Operation"
(Coroner's Verdict)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. 16 ds.
(Signed) C E Linnoodey M. D.
7-23 1920 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence ..... ship.

19. PLACE OF BURIAL OR REMOVAL: Sugar City, Ida. DATE OF BURIAL: 7-23 1920

20. UNDERTAKER: C E Linnoodey ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31121

Registered No. 111

1. PLACE OF DEATH

County of Bonneville

City of Ida Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2 1 N 2

(No. ....., ... St.)

2. FULL NAME Baby Tanner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: July (Month) 23 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many 7 hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Ben Ellsworth

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lucile Tanner

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C E Dunwoody

(Address) Ida Falls Ida

15. Filed July 26 1920 Wm Simmonds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1920 to July 23 1920

that I last saw him alive on July 23 1920

and that death occurred on the date stated above, at 11 P M

The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G W Pendleton M. D.

7/24 1920 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida — DATE OF BURIAL: 7/24/20

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

Dr Pendleton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 2107
File No. 31122
Registered No. 110

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruby J Harris
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)
6. DATE OF BIRTH: July 31 1899 (Month) (Day) (Year)
7. AGE: 20 Yrs. 10 Mos. 28 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): Clerking in Store
9. BIRTHPLACE (State or Country): Kansas
10. NAME OF FATHER: C. S. Harris
11. BIRTHPLACE OF FATHER (State or Country): Mo
12. MAIDEN NAME OF MOTHER: Marcha E Washington
13. BIRTHPLACE OF MOTHER (State or Country): ~~Kans~~ Va
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. S. Harris
(Address) Idaho Falls, Ida
15. Filed July 29 1920 W. M. Freeman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 28 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 28 1920 to June 28 1920
that I last saw her alive on June 28 1920
and that death occurred on the date stated above, at 11a M.
The CAUSE OF DEATH* was as follows:
Embolism Following Operation (Shock, Sudden death)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Renal Failure
(Duration) Sudden Yrs. ..... mos. ..... ds.
(Signed) J. E. Shupe M. D.
6/30 1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence 7/1

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls, Ida
DATE OF BURIAL: 7/1 1920

20. UNDERTAKER: E. A. Linwood
ADDRESS: Ida Falls

Dr Shupe

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31123
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 29
Primary Registration District No. 2156
(No. ....., ... St.)

1. PLACE OF DEATH
County of Boundary
City of Copeland
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Buster Roesch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 17 (Day) 1917 (Year)

7. AGE ..... Yrs. 4 Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Jacob Roesch

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Christine Alden

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Roesch
(Address) .....

15. Filed July 20 1920 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... July (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Burned to death (accidental)

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) C. D. Simonds Coroner ~~M. D.~~
.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL Porthill Idaho — DATE OF BURIAL July 24. 1920.

20. UNDERTAKER O R Bloomy — ADDRESS Bonners Ferry Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH 79

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31124
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Boundary
City of Copeland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. 1816
(No. ....., ... St.)

2. FULL NAME Ellen Roach

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) ..... (Day) 1917 (Year)

7. AGE: 3 Yrs. 2 Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Jacob Roach

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Christina Ellen

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Roach
(Address) .....

15. Filed July 20 1920. ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... July (Month) ..... 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Burned to death (Accidental)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) ..... Coroner M. D.

..... 19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Idaho — DATE OF BURIAL July 24 1920.

20. UNDERTAKER O R Stookey — ADDRESS Bonners Ferry Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3125
Registered No. .....

Registration District No. 74
Primary Registration District No. 5156
(No. ....., ... St.)

1. PLACE OF DEATH
County of Boundary
City of Copeland
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Esther Helen Roesch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 15 (Day) 1916 (Year)

7. AGE: 4 Yrs. 2 Mos. 29 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Jacob Roesch

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Christina Elder

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Roesch
(Address) .....

15. Filed July 20 1920 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Burned to death (accidental)

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory .....
(Secondary)

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) C. D. Simonds Coroner M. D.

.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Portland Idaho — DATE OF BURIAL July 24 1920.

20. UNDERTAKER H. D. Stookey — ADDRESS Bonners Ferry Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31126

Registration District No. 39
Primary Registration District No. 215-6
(No. ....., ... St.)

1. PLACE OF DEATH
County of Boundary
City of Copeland
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Adolph Roesch

Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1913 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John Jacob Roesch

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Christine Ebler

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Roesch
(Address) .....

15. Filed July 20 1920 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... July (Month) ..... 17 (Day) ..... 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

..... Burned to death (accidental)
.....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. D. Simmons Coroner M. D.
..... 19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Dorthill Ida — DATE OF BURIAL July 24 1920.

20. UNDERTAKER M Stookey — ADDRESS Bonners Ferry Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5121
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 79
Primary Registration District No. 3156
(No. ....., ... St.)

1. PLACE OF DEATH
County of Boundary
City of Copeland
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Walter Roesch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 17 (Day) 1911 (Year)

7. AGE: 9 Yrs. 4 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Jacob Roesch

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Christina Ade

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Roesch
(Address) .....

15. Filed July 20 1920. E E Ivy Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... July (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

..... Burned to death (accidental)
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) C. D. Simonds Coroner ~~M. D.~~
.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Corthill Idaho
DATE OF BURIAL: July 24. 1920.

20. UNDERTAKER: M Toomy
ADDRESS: Bonners Ferry Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 71
Primary Registration District No. 216
File No. 21128
Registered No.

1. PLACE OF DEATH
County of Boundary
City of Copeland
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Christina Roesch

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Wid

6. DATE OF BIRTH. Sept (Month) ..... 1906 (Year)

7. AGE: 13 Yrs. 10 Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER John Jacob Roesch

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Mary Christina Elder

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Roesch
(Address) .....

15. Filed July 20 – 1920. E E Lee Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Burned to Death (accidental)

.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory .....
(Secondary)
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) C D Simonds Coroner M. D.
.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days, In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Ida
DATE OF BURIAL July 21 1920
20. UNDERTAKER O Wilson Bay
ADDRESS Bonners Ferry Ida

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31129
Registered No. .....

Registration District No. 39
Primary Registration District No. 2156
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Boundary
City of Copeland

2. FULL NAME Clara Magdalene Roesch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) ..... (Day) 1906 (Year)

7. AGE: 13 Yrs. 10 Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: John James Roesch

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Christine Oakes

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Roesch
(Address) .....

15. Filed July 20 1920 ..... E. E. True, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... July (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:

..... Burned to death, (accidental)
.....
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory .....
(Secondary)
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) C. D. Simonds ..... Coroner M. D.
.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Northhill Idaho — DATE OF BURIAL: July 24 1920

20. UNDERTAKER: M. Stookey — ADDRESS: Bonners Ferry Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31130
Registered No. .....

Registration District No. 39
Primary Registration District No. 3156
(No. ....., ... St.)

1. PLACE OF DEATH
County of Boundary
City of Copeland
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Christine Rosch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 29 (Day) 1856 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Geo J. Olden

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Maggie B Beeth

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John J. Rosch
(Address) .....

15. Filed July 20 1920. E E Fry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... July (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Burned to death (accidental)

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs..... mos..... ds.

(Signed) C. D. Simonds Coroner M. D.

.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Portkill Idaho
DATE OF BURIAL: July 24. 1920.

20. UNDERTAKER: O R Stookey
ADDRESS: Bonners Ferry Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Butte

City of Arco

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 09

Primary Registration District No. 2129

(No. ....., ... St.)

File No. 31131

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Drew Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept — (Month) (Day) 1846 (Year)

7. AGE: 74 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Louisiana

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Johnson

(Address) Twin Falls, Idaho

15. Filed July 3 1920

Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1920 to July 3 1920

that I last saw him alive on July 3 1920

and that death occurred on the date stated above, at 10 2 M.

The CAUSE OF DEATH* was as follows:

D. P. W. abdomen

Hemorrhage + Shock

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E W Sh M. D.

7/3 1920 (Address) Arco, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Arco Idaho — DATE OF BURIAL: 7-5 1920

20. UNDERTAKER: W D Smith — ADDRESS: Arco, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 31132
Registered No. 1032

1. PLACE OF DEATH
County of Gooding
City of Near the dale (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Elam Trotter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: 3 (Month) 16 (Day) 1885 (Year)

7. AGE: 35 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Editor
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Marion Trotter

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Martha Crawford

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. F. E. Trotter
(Address) Wendell

15. Filed 8-3-1920 John L. Mayes, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1920 to July 1 1920 that I last saw h. alive on July 1 1920 and that death occurred on the date stated above, at 5 A.M. The CAUSE OF DEATH was as follows:

Peritonitis + shock

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Gun shot wound
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Lawson Hopkins M. D.
19..... (Address) Homedale Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 8-3 1920

20. UNDERTAKER: CASE FURNITURE CO
ADDRESS: Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1004
File No. 31133
Registered No. 104

1. PLACE OF DEATH
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Elizabeth Skelton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY; WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Apr. (Month) 9 (Day) 1832 (Year)

7. AGE: 88 Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Petch

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Walkdon

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Skelton
(Address) 1614 Fillmore Caldwell

15. Filed July 30 1920 John A. Meyer, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 19 18 to July 29 1920
that I last saw her alive on ..... 19 .....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Coe M. D.
July 29 1920 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 7-30 1920

20. UNDERTAKER: CASE FURNITURE CO
ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

[redacted]

1. PLACE OF DEATH

Registration District No. ..... State of ...

County of Canyon — Primary Registration District No. 2005 — File No. 31134

City of Caldwell — (No. ....., ... St.) — Registered No. 103

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edwin Wyatt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 24 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: A. E. Wyatt

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Lucy Harkless

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. T. Biggs

(Address) Star Idaho.

15. Filed 7-30-1920 John O. Meyer. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 3-15 P.M.

The CAUSE OF DEATH* was as follows:

Stroke of lightning

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. V. Peckham M. D.

7-30 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Superior Nebr. — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: C. V. Peckham — ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 2005
File No. 31135
Registered No. 102

1. PLACE OF DEATH
County of Canyon
City of Caldwell,
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rachael Ann Norris
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: July (Month) 27 (Day) 1827 (Year)

7. AGE: 73 Yrs. 7 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Brackney

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Susannah Haworth

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. H. Commons
(Address) Caldwell, Ida.

15. Filed 7-30- 1920 John V. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16" 1920 to July 29" 1920
that I last saw h.er alive on July 16" 1920
and that death occurred on the date stated above, at 5-10 A.M.
The CAUSE OF DEATH* was as follows:

General Debility

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Henry M. D.
July 29 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] | DATE OF BURIAL ..... 19..

20. UNDERTAKER: [illegible] Buckham | ADDRESS Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1095
File No. 31136
Registered No. 101

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Lennox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 5 (Day) 1899 (Year)

7. AGE: 21 Yrs. ..... Mos. 22 ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Fred Hallett

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Desdemona Miles
(Address) 300 Chicago — Caldwell Idaho

15. Filed 7-27- 1920 John S. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26" 1920, to July 27" 1920, that I last saw h.. alive on July 27" 1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Appendicitis with
Ruptured appendix
(Duration) ..... Yrs. ..... mos. 31 ds.

Contributory (Secondary) Abortion followed by septic infection
(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) J. M. Henry M. D.
July 27 1920. (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 7-29 1920

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 31137
Registered No. 105

1. PLACE OF DEATH
County of Canyon
City of Wilder
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Stephens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Feb (Month) 21 (Day) 1855 (Year)

7. AGE: 65 Yrs. 5 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England.

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Henry Stephens
(Address) Huston RD #2

15. Filed July 27 1920 John S. Moyes
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 17 1920, to July 26 1920
that I last saw h. liv. alive on July 5 1920
and that death occurred on the date stated above, at 12-20 M.
The CAUSE OF DEATH* was as follows:
Tuberculosis, chronic pulmonary, involving both lungs
(Duration) Yrs. 6 mos. — ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. T. Bauer M. D.
7/26 1920 (Address) Wilder Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wilder Cemetery	7-27 1920
20. UNDERTAKER	ADDRESS
E. E. Beckham	Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2005
File No. 31138
Registered No. 69

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy A. Houdyshell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1885 (Year)

7. AGE: 34 Yrs. 10 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: H. S. Houdyshell

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mellisa VanNess

13. BIRTHPLACE OF MOTHER (State or Country): Ills.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hazel Houdyshell
(Address) Caldwell, R. 1.

15. Filed 7-26-1920 John V. Meyer, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1920, to July 25 1920, that I last saw h[illegible] alive on July 24 1920, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:
Cardiac Embolus.
..... (Duration) ..... Yrs. sudden mos. ..... ds.
Contributory (Secondary) Fracture of leg.
..... (Duration) ..... yrs. ..... mos. 20 ds.
(Signed) [illegible] M. D.
7/26 1920 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 7-28 1920

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 31139
Registered No. 98

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Melton.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: July (Month) 22 (Day) 1844 (Year)

7. AGE: 75 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: William Melton.

11. BIRTHPLACE OF FATHER (State or Country): Virginia.

12. MAIDEN NAME OF MOTHER: Jane Cox.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. G. Sykes
(Address) Huston #1

15. Filed 7-20- 1920 Jos. V. Mayes. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920, to July 19 1920, that I last saw him alive on July 14 1920, and that death occurred on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Heart Exhaustion from failure of compensatory hypertrophy due to valvular sclerosis.

(Duration) One Month Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia - 2 mos ago

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Geo. R. Proctor M. D.

19..... (Address) Nampa - Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	7-20 1920
20. UNDERTAKER E. V. Bonham	ADDRESS Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2005
File No. 31140
Registered No. 97

1. PLACE OF DEATH.
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Everett Shelton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: [redacted] (Month) 5 (Day) 1920 (Year)
7. AGE: ..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Canyon Co Idaho
10. NAME OF FATHER: Clarence Shelton
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Ella Lampe
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Loarena Shelton
(Address) Star Ida
15. Filed July 17 1920 Jos. E. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 16 1920 that I last saw h[illegible] alive on July 16 1920 and that death occured on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows: Premature Birth 7 mos.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... Yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
7/17 1920 (Address) Star, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Star Cem. DATE OF BURIAL: 7-17 1920
20. UNDERTAKER: [illegible] ADDRESS: Caldwell

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 31141
Registered No. 96

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Rode

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Sept. 25 (Month) (Day) 1854 (Year)

7. AGE: 65 Yrs. 9 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: William Rode.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Louisa Blakely.

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs M C Rode
(Address) Caldwell, Idaho

15. Filed July 16 1920 John S. Meyer, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 24 1920 to July 16 1920
that I last saw h.... alive on June 26 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Paralysis—Cerebral

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) /

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C M Haley M. D.
7-19 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	7-18 1920
20. UNDERTAKER	ADDRESS
Pickham	Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 1005

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31142

Registered No. 93

1. **PLACE OF DEATH**

County of Canyon

City of Caldwell

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Lewie Quongmen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	Chinese	~~(Write the word.)~~ Married

6. **DATE OF BIRTH**

..... (Month) ..... (Day) 1 (Year)

7. **AGE** 49 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Gardner

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) China

10. **NAME OF FATHER** Lewie

11. **BIRTHPLACE OF FATHER** (State or Country) China.

12. **MAIDEN NAME OF MOTHER**

13. **BIRTHPLACE OF MOTHER** (State or Country) China.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Lewie Quong

(Address) Caldwell, Idaho

15. Filed 7-18-1920 John H. Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Found dead at home! Complained of heart and went to bedroom alone

Past history of ulcers indigestion

Contributory (Secondary) and bowel complaint

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. V. Peckham Coroner.

7/18 1920 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hong Kong China	19.....
20. UNDERTAKER O. V. Peckham	**ADDRESS** Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2007
File No. 31143
Registered No. .....

1. PLACE OF DEATH.
County of Canyon Co
City of Parma Ida
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Taylor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. September (8) (Month) (Day) 1835 (Year)

7. AGE: 84 Yrs. 10 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER John B. Taylor

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Elizabeth Campbell

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. E. E. Allen.
(Address) Parma, Idaho.

15. Filed July 25 1920 Lula Waldrop Local Registrar

SYMS - YORK CO., PTGS. & STNRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH. July (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to July 25 1920, that I last saw h[illegible] alive on July 24 1920, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... mos. ..... ds.

(Signed) A. M. Mitchell M. D.

7/25 1920 (Address) Parma Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nora Iowa | DATE OF BURIAL: July 191

20. UNDERTAKER: Peckham Furniture Parma | ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 31144
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. 8th st & 18th Ave)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Nelson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 5 (Day) 1856 (Year)

7. AGE: 63 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Jas Nelson
(Address) Nampa Ida

15. Filed Aug. 10 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1920, to Aug 3 1920
that I last saw h... alive on July 30 1920
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease
(Duration) About 1 yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) Geo. R. Proctor M. D.
8/10 1920 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	8-5 1920
20. UNDERTAKER	ADDRESS
Fred K. Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 31145
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes A Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Single

6. DATE OF BIRTH Dec (Month) 24 (Day) 1889 (Year)

7. AGE 30 Yrs. 7 Mos. 11 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Minn

10. NAME OF FATHER N Miller

11. BIRTHPLACE OF FATHER (State or Country) Wis

12. MAIDEN NAME OF MOTHER Mary Weber

13. BIRTHPLACE OF MOTHER (State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo B. Miller

(Address) Sago Mont

15.

Filed Aug. 10 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 3 (Day) 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 - 1920 to Aug. 3 - 1920

that I last saw her alive on Aug. 3 - 1920

and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

General Peritonitis,

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) Acute Gangrenous Appendix

(Duration) yrs. mos. 4 ds.

(Signed) F. B. Smith M. D.

8-10-1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Osage Iowa

DATE OF BURIAL 19

20. UNDERTAKER F K Robinson

ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 31146
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. Nazarene Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert M Hibbard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE

41 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER M. Hibbard

11. BIRTHPLACE OF FATHER (State or Country) Ill

12. MAIDEN NAME OF MOTHER Francis Griswold

13. BIRTHPLACE OF MOTHER (State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs H.M. Hibbard
(Address) Nampa, Ida.

15.

Filed Aug 10 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 6 (Day) 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1920, to Aug 9 1920
that I last saw h. alive on Aug 5 1920
and that death occurred on the date stated above, at 6:20 A.M.
The CAUSE OF DEATH* was as follows:

Ruptured Appendix

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Thos. E. Mangum M. D.
8-9-1920 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn Cem	8-10-1920

20. UNDERTAKER	ADDRESS
F K Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 31147
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Jean Knapp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH Apr. (Month) 17 (Day) 1919 (Year)

7. AGE 1 Yrs. 2 Mos. 19 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nampa Idaho

10. NAME OF FATHER S. P. Knapp

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Mabel C. Randall

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. P. Knapp

(Address) 6 St. & 21 Ave.

15. Filed July 24 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 2 1920 **to** July 7 1920 **that I last saw h.** alive on July 7 1920 **and that death occurred on the date stated above, at** 8 a. M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. F. Mussey M. D.

July 8 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Kohlerlawn Cem. **DATE OF BURIAL** 7-8 1920

20. UNDERTAKER H. Robinson **ADDRESS** Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 7

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31148

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosannah C. Bradley.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~ (Write the word): Married

6. DATE OF BIRTH: Feb (Month) 16 (Day) 1845 (Year)

7. AGE: 75 Yrs. 5 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: C. C. Creamer

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Elizabeth Hyde

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Henery O Bradley

(Address) Nampa Ida

15. Filed July 21 1920 Pearle Dodds Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920, to July 18 1920, that I last saw h.r alive on July 18 1920 and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Murray M. D.

7-19 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Holdridge Field DATE OF BURIAL: 7-20 1920

20. UNDERTAKER: F. T. Robinson ADDRESS: Nampa

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31149

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1806

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis E Adams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1862 (Year)

7. AGE: 58 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: F. A. Doty.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Susan Owens

13. BIRTHPLACE OF MOTHER (State or Country): ~

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. E. Jacobs

(Address) Nampa Ida

15. Filed July 24 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3 1920 to July 17 1920 that I last saw h[illegible] alive on July 17 1920 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J W Murray M. D.

7-18 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boulder Grove Cem. DATE OF BURIAL: 7-16 1920

20. UNDERTAKER: F K Robinson ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Murray

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3115

Registration District No. ____
Primary Registration District No. 1006
(No. Cor. 4th & Holt & Orchard)
Registered No. ____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel Sites

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Feb (Month) 27 (Day) 1839 (Year)

7. AGE: 81 Yrs. 7 Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): (Retired)

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Nancy Worley

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Sites
(Address) Nampa Ida

15. Filed July 22 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1920, to ____ 19____, that I last saw h was alive on ____ 19____ and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:
Senile heart failure

(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Chronic Bronchitis
(Duration) 5 yrs. ____ mos. ____ ds.

(Signed) J. F. Murray M. D.
July 15 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 7-17 1920

20. UNDERTAKER: Fred Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

M

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 31151
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Douglas Pendleton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: caucasion
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): divorced

6. DATE OF BIRTH: June (Month) 21 (Day) 1878 (Year)

7. AGE: 42 Yrs. 1 Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: clerk
(b) General nature of industry, business or establishment in which employed (or employer): cigar store

9. BIRTHPLACE (State or Country): Lawrence Co. Mo.

10. NAME OF FATHER: W.P. Pendleton

11. BIRTHPLACE OF FATHER (State or Country): Lawrence Co. Mo.

12. MAIDEN NAME OF MOTHER: Kisirah Arnhart

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Lola Carlisle
(Address): Nampa, Ida.

15.
Filed July 24 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5 P.M. July 21 1920, to 7:30 P.M. July 21 1920
that I last saw h~~im~~ alive on July 21 1920
and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Acute Peritonitis
due to ruptured Ulcer
(Duration) — Yrs. — mos. 1 ds.
Contributory (Secondary) Duodenal Ulcer
(Duration) Don't Know Yrs. mos. ds.

(Signed) Leo N. Chilton M. D.
19 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: F.P. Robinson — DATE OF BURIAL: 7-23 1920

20. UNDERTAKER: Kohlenberg — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2506
File No. 31152
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anonymous Belonger
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Unknown

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: 91 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. T. Boyd
(Address) Nampa

15. Filed July 27 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1920 to July 23 1920 that I last saw h[illegible] alive on July 22 1920 and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Senile Decay

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr. T. Boyd M. D.
19 (Address) Dr. T. Boyd

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. 1 mos. 4 days. In the State yrs. mos. days
Where was disease contracted if not at place of death? Orofino Idaho
Former or usual residence Lyle Idaho

19. PLACE OF BURIAL OR REMOVAL: Kohlerdown — DATE OF BURIAL: 7-27-1920
20. UNDERTAKER: [illegible] — ADDRESS: [illegible]

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31153
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1006
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alfaretta Ophalia Westbrook

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Widow

6. DATE OF BIRTH: March (Month) 8 (Day) 1848 (Year)

7. AGE: 72 Yrs. Mos. 4 ds. 23
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Jeremiah Stenway

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Diana Wood

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W Neubaum
(Address) Nampa Idaho

15.
Filed Aug. 10 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 1st. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1920, to Aug 1st. 1920
that I last saw her alive on Aug 1st. 1920
and that death occurred on the date stated above, at 1:20 P.M.
The CAUSE OF DEATH* was as follows:

Acute intestional obstruction
due to paralysis.
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Scott M. D.
Aug 7 1920 (Address) Nampa Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 2 mos. 4 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Peabody Kansas

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Peabody Kansas	..... 19.....
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Kuna

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 2004

(No. ..... St.)

File No. 31154

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Christenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: Febr (Month) 4 (Day) 1860 (Year)

7. AGE: 60 Yrs. 5 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Chris Christenson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Mary A. Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. C. Christenson
(Address) Kuna Ida

15. Filed Aug. 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Dropsy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

7-24 19.. (Address) [illegible]

*State the *Disease Causing Death*; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hohenbower Cem. DATE OF BURIAL: 7-24 1920

20. UNDERTAKER: F. M. Robinson ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Stony

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 31155
Registered No. 442

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Elizabeth Judd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Aug. (Month) 12. (Day) 1849. (Year)

7. AGE: 71 Yrs. 10 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Allen Lambson

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Ellen Nick

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Solomon Hansen
(Address) R. F. D. #2, Burley Ida.

15. Filed July 19th 1920 H. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 16 1920, to Apr 26 1920, that I last saw h[illegible] alive on Apr 26 1920, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Endocarditis with
Pulmonary Edema

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. J. Story M. D.
19..... (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida — DATE OF BURIAL: June 29 1920

20. UNDERTAKER: L. B. Talloghy. — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Cutler

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117

Primary Registration District No. 2196

File No. 3156

Registered No. 471

1. PLACE OF DEATH.

County of Cassia

City of Burley

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Arnetad Moffett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.: Aug. (Month) 6. (Day) 1860. (Year)

7. AGE: 69 Yrs. 10 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Arnetad Moffett.

11. BIRTHPLACE OF FATHER (State or Country): W. Va.

12. MAIDEN NAME OF MOTHER: Mary Jane Emmett

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. M. Moffett

(Address) R. F. D. 2 Burley Ida.

15.

Filed July 19 1920

D. J. C. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29. (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1920, to June 29 1920, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: View Ida.

DATE OF BURIAL: 7-3 1920

20. UNDERTAKER: L. D. Talloyle

ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 31157
Registered No. 440

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pedro Rodriguez.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Unknown

6. DATE OF BIRTH. Unknown (Month) (Day) 1 (Year)

7. AGE: 39 Yrs. 0 Mos. 35 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer in Beet Fields.
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Old Mexico.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L. B. Galloglys
(Address) Burley Ida.

15. Filed July 5 1920 W. J. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Shot wound thru Chest, by an Officer
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) L. B. Galloglys = Coroner = M. D.
7/6/ 20 (Address) Burley Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: July 6 1920

20. UNDERTAKER: L. B. Galloglys ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31158
Registered No. 439

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley

2. FULL NAME Effie Ross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Oct (Month) 22 (Day) 1886 (Year)

7. AGE 34 Yrs. 8 Mos. 26 ds. IF LESS THAN 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nebr

10. NAME OF FATHER Charles Johnson

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Mary Hannah Gambrel

13. BIRTHPLACE OF MOTHER (State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. D. Ross
(Address) Burley Ida

15.
Filed July 17 1920 Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 15 1920 to July 18 1920
that I last saw her alive on July 18 1920
and that death occurred on the date stated above, at 5:30 p. M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease

(Duration) several Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
7-19-1920 (Address) Burley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Twin Falls Ida — **DATE OF BURIAL** or arrival

20. UNDERTAKER Reverett — **ADDRESS** Burley Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 31159
Registered No. 438

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Joseph Carrol
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Jan. (Month) 16 (Day) 1867 (Year)

7. AGE
53 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Contractor
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Canada.

10. NAME OF FATHER: John Carrol.

11. BIRTHPLACE OF FATHER
(State or Country) Canada.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER
(State or Country) Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. J. J. Carrol.
(Address) Burley Ida.

15.
Filed July 12 1920
Dr. J. C. Patterson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1920, to July 10 1920, that I last saw him alive on July 10 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Septicaemia following carbuncle of neck
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Lobar Pneumonia
(Duration) ..... yrs. ..... mos. 20 ds.
(Signed) G. M. Gunth M. D.
7/12 1920 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kenosha Wisc.
DATE OF BURIAL: July 15 1920.

20. UNDERTAKER: L. B. Tillotson
ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PYRS. & SONS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Cooper

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 31160
Registered No. 437

1. PLACE OF DEATH.
County of Cassia
City of Burley
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie Grimm

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH. Nov. (Month) 19 (Day) 1894 (Year)

7. AGE: 26 Yrs. 7 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Lowa

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William Hugh

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary McKean

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. A. Grimm
(Address) Box #91. Paul Idaho

15. Filed July 10 1920 D. J. C. Patterson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1920, to July 9 1920, that I last saw her alive on July 9 1920, and that death occured on the date stated above, at — P.M.

The CAUSE OF DEATH* was as follows:
Acute Endocarditis

— (Duration) — Yrs. — mos. 14 ds.
Contributory (Secondary) Endocarditis
(Duration — yrs. — mos. — ds.

(Signed) G. H. Cooper M. D.
7-10 1920 (Address) Burley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 15 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt. Angel Oregon — DATE OF BURIAL: July 13th 1920

20. UNDERTAKER: L. O. Calloway — ADDRESS: Burley Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 122
Primary Registration District No. 2199
File No. 34463
Registered No.

1. PLACE OF DEATH.
County of Cassia
City of Oakley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Raymond Dahlquist

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. January (Month) 7 (Day) 1843 (Year)

7. AGE: 27 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Oakley Canal Company

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Dahlquist

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ida Christina Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Ida Dahlquist
(Address) Oakley Ida.

15. Filed Aug 8 1930 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 20 1930, to July 24 1930, that I last saw him alive on July 24 1930 and that death occured on the date stated above, at 5a. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage?

(Duration) ..... Yrs. ..... mos. 1/4 ds.
Contributory (Secondary) Alcoholism?
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jesse L. Raine M. D.
July 24 1930 (Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oakley Ida — DATE OF BURIAL: July 24 1930

20. UNDERTAKER: Galloway — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STNRS. 24653

Form V. S. No. 1-35 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 768
File No. 31164
Registered No. 3

PLACE OF DEATH

County Nezperce
City of Orofino (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clay Swank

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March 20 1892 (Month) (Day) (Year)

7. AGE: 28 Yrs. 3 Mo. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: John Swank

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary O'Neil

13. BIRTHPLACE OF MOTHER (State or Country): N. C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed July 19 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 17 1920 to July 16 1920 that I last saw him alive on July 16 1920, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) About yrs. 3 mos. 4 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Fairley M. D.
7/19 1920 (Address) Orofino, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino DATE OF BURIAL: July 19 1920

20. UNDERTAKER: W. E. Goddard ADDRESS: Orofino

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 91
Primary Registration District No. 2168
File No. 31165
(No. ....., ... St.)
Registered No. .....

1. PLACE OF DEATH.
County of Clearwater
City of Elk Rivers
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James O'Donnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. Dec. (Month) 2 (Day) 1836 (Year)
7. AGE: 83 Yrs. 5 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work... X
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Canada
10. NAME OF FATHER Michel O'Donnell
11. BIRTHPLACE OF FATHER (State or Country) Canada
12. MAIDEN NAME OF MOTHER Mary Raney
13. BIRTHPLACE OF MOTHER (State or Country) Ireland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ed O'Donnell
(Address) Elk River
15. Filed May 22 1920 Mrs. F. P. McConnell Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 20 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 10 1920, to May 15 1920, that I last saw h. alive on May 15 1920 and that death occured on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows: May 20
apoplexy
(Duration) Yrs. mos. 20 ds.
Contributory (Secondary) Old age
(Duration yrs. mos. ds.
(Signed) ..... M. D.
May 22 1920 (Address) Elk River, Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash — DATE OF BURIAL: ..... 191.....
20. UNDERTAKER: H. E. Hunt — ADDRESS: St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 91

File No. 31166

County of Clearwater

Primary Registration District No.

Registered No.

City of Elk River

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elnora Mae Foster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March (Month) 17th (Day) 1878 (Year)

7. AGE: 42 Yrs. 3 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: James C. Chandler

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Mary Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leonard Foster

(Address) Elk River Ida

15.

Filed June 16 1920 Mr F P M Cormack Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 9. 10 M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. P. M. Cormack M. D.

June 16 1920 (Address) Elk River Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dragoon Iowa — DATE OF BURIAL ..... 191...

20. UNDERTAKER: H E Hunt & Co — ADDRESS St Maries Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - STAR CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH Executive

Registration District No.....

County of Latah

Primary Registration District No.....

File No. 31167

City of Elberon

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William E. Stack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 15 (Day) 1858 (Year)

7. AGE: 62 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Lumber scaler.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): New brunswick

10. NAME OF FATHER: W. F. Stack

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. L. Stack
(Address) Spokane Wash.

15.
Filed ..... 191.....
Mrs. F. E. McCormick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1920, to July 19 1920, that I last saw him alive on July 19 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Fracture pubic Bone. rupture of Bladder & C pneumonia Right leg two third
(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. P. McCormick M. D.
July 20 1920 (Address) East Bunn Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 2 days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane — DATE OF BURIAL ..... 191.....

20. UNDERTAKER: E. M. Irwin — ADDRESS

SYMS - YORK CO., PTRS. & BOKS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 91
Primary Registration District No. 2168
File No. 31168
Registered No. .....

1. PLACE OF DEATH.
County of Shoshone
City of Elk River
(No. E.R. Prison Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Swanson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 17 (Day) 1899 (Year)

7. AGE: 21 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Daniel Swanson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Matilda Enslafsen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Gust Swanson
(Address) Spokane Wash

15. Filed June 15 1920 M. P. McInnis Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1920, to June 15 1920, that I last saw h/M alive on June 14 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Appendicitis + General peritonitis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. P. McInnis M. D.
June 15 1920 (Address) Elk River Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elk River — DATE OF BURIAL: June 16 1920

20. UNDERTAKER: Morris & Son — ADDRESS: Elk River

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 31170
Registered No. 23

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jane Winstanley Caldwell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 14 (Day) 1836 (Year)

7. AGE: 84 Yrs. 4 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Lynn Cheshire England

10. NAME OF FATHER: John Winstanley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Yasker

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J W Caldwell
(Address) Mtn Home Ida

15. Filed July 4th 1920
B W Mathes Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1919, to 7-2- 1920 that I last saw h-er alive on 7-2- 1920, and that death occurred on the date stated above, at 955 P M.
The CAUSE OF DEATH* was as follows:

Obstructed Bowels

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Senility & Fractured neck of left femur
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J E Evans M. D.
7-24-1920 (Address) Mtn Home

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Ida — DATE OF BURIAL: 7-4 1920

20. UNDERTAKER: A E Cowan — ADDRESS: Mtn Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 3171
Registered No. 22

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Anna Lager
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	single

6. DATE OF BIRTH: July (Month) 12 (Day) 1899 (Year)

7. AGE: 21 Yrs. — Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida

10. NAME OF FATHER: H A Lager

11. BIRTHPLACE OF FATHER (State or Country): Schorberg Holstein Germany

12. MAIDEN NAME OF MOTHER: Martha Giese

13. BIRTHPLACE OF MOTHER (State or Country): Schorberg Holstein Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H A Lager
(Address) Mtn Home Ida

15. Filed July 24th 1920 — Burdlather, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10 1919, to July 23d 1920
that I last saw h[er] alive on July 23d 1920
and that death occurred on the date stated above, at 1:15 P.M.
The CAUSE OF DEATH* was as follows:
Epilepsy
(Duration) 5 Yrs. — mos. — ds.
Contributory (Secondary) Exhaustion
(Duration) ..... yrs. 2 mos. ..... ds.
(Signed) Burdlather M. D.
7/24 1920 (Address) Mtn. Home, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	7-25 1920

20. UNDERTAKER	ADDRESS
A W Conover	Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 34

Primary Registration District No. 2020

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31172

Registered No. 20

1. PLACE OF DEATH

County of Elmore

City of Mtn Home

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William J. C. Riddell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Oct 3 (Month) (Day) 1860 (Year)

7. AGE: 59 Yrs. 7 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Straghharm Scotland

10. NAME OF FATHER: Abram Riddell

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margaret Cobban

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Christene Riddell

(Address) Mtn. Home Ida.

15. Filed May 25th 1920

E. W. Walther
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 14 1920 to May 23 1920 that I last saw h[illegible] alive on May 22 1920 and that death occurred on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows: Rocky Mtn. Spotted Fever

..... (Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Evens M. D.

5-24 1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mtn Home — DATE OF BURIAL: May 25 1920

20. UNDERTAKER: A. W. Conover — ADDRESS: Mtn Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 31173
Registered No. 25

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Philip Ripper
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	unknown

6. DATE OF BIRTH
unknown (Month) ..... 1 (Day) ..... (Year)

7. AGE
78 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: do

11. BIRTHPLACE OF FATHER (State or Country): do

12. MAIDEN NAME OF MOTHER: do

13. BIRTHPLACE OF MOTHER (State or Country): do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. W. Conover per
(Address) Mtn. Home B.O. M

15. Filed July 9th 1920
B. W. Mather
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7, 1920, to July 8 1920
that I last saw h.. alive on July 8 1920
and that death occurred on the date stated above, at 1:15 P M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. E. Evans M. D.
7-24 1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mtn Home Ida	7-10- 1920
20. UNDERTAKER	ADDRESS
A W Conover	Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 31174
Registered No. 24

1. PLACE OF DEATH
County of Elmore
City of Mtn. Home Ida, (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME x Eunice Ross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Married~~ (Use the word.)

6. DATE OF BIRTH: x Nov 9 1841 (Month) (Day) (Year)

7. AGE: 78 Yrs. 6 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: x house wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): x Markham Canada

10. NAME OF FATHER: x Mr allen

11. BIRTHPLACE OF FATHER (State or Country): x England

12. MAIDEN NAME OF MOTHER: x

13. BIRTHPLACE OF MOTHER (State or Country): x England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) x W a Ross
(Address) x Emmett, Idaho

15. Filed 7/29 1920 — Bud Walker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: x May 27 (27th) 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from x-25-1920, to 5-27-1920, that I last saw h~~er~~ alive on ——— 19..., and that death occurred on the date stated above, at x 5:45 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Arthritis

(Duration) 14 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J E Evans M. D.
7-27-1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Ida — DATE OF BURIAL: 5-27-1920

20. UNDERTAKER: A W Conner — ADDRESS: Mtn Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 31175
Registered No. 19

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Samson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April 5 1882 (Month) (Day) (Year)

7. AGE: 38 Yrs. 2 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wazeka Wisconsin

10. NAME OF FATHER: Samuel N. Pierce

11. BIRTHPLACE OF FATHER (State or Country): New Bedford Mass

12. MAIDEN NAME OF MOTHER: Adeline Lathrop

13. BIRTHPLACE OF MOTHER (State or Country): Wazeka Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Watson R. Samson
(Address) Grand View Ida

15. Filed June 16th 1920 — B. W. Mather, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June 15 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h.. alive on June 15th 1920
and that death occurred on the date stated above, at 7.00 P. M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. E. Ken Grack M. D.
6/16 1920 (Address) Grand View per V.B.M.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home — DATE OF BURIAL: 6—20 1920

20. UNDERTAKER: C. W. Connorr — ADDRESS: Mtn Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 31176
Registered No. 21

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claude Yates
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 22 (Day) 1867 (Year)

7. AGE: 52 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Campaign Co Illinois

10. NAME OF FATHER: Nathaniel H Yeats

11. BIRTHPLACE OF FATHER (State or Country): Brown Co. Indiana

12. MAIDEN NAME OF MOTHER: Mary E Likens

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Effie A Lemasters
(Address) Yakima Wash

15. Filed June 7th 1920 By Wallace Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 11.20a M.
The CAUSE OF DEATH* was as follows:
Gun shot wound from gun in the hand of W H Evans
Instant (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W H Easton, Coroner M. D.
6/8 1920 (Address) Mtn Home, Elmore Co.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home — DATE OF BURIAL: 6-9 1920

20. UNDERTAKER: E W Conover — ADDRESS: Mtn Home

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31178

Registered No.

1. PLACE OF DEATH

County of Franklin

City of Preston

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth W Monson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July 15 (Month) (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 4 hrs. or 0 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Vernon Louis Monson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Clara Westover

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Vernon L Monson

(Address) Preston Idaho

15. Filed ..... 19..... D A Ritter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 16 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 16 1920 that I last saw h[illegible] alive on July 15 1920 and that death occurred on the date stated above, at 2A M.

The CAUSE OF DEATH* was as follows:

Six months gestation

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Hand M. D.

7/7 1921 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston

DATE OF BURIAL: July 19 21

20. UNDERTAKER

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31179
Registered No.

Registration District No.
Primary Registration District No.
(No. , St.)

1. PLACE OF DEATH
County of Franklin
City of Preston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Keith H Monson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 15 (Day) 1920 (Year)

7. AGE: ....Yrs. ....Mos. ....ds.
IF LESS than 1 day how many 8 hrs. or 55 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Vernon Louis Monson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Clara Weston

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Vernon L Monson
(Address): Preston Idaho

15.
Filed ....19....
D A Rudd
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 16 1920
that I last saw h.i.m. alive on July 15 1920
and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows:

Six Months gestation

....(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

....(Duration) ....yrs. ....mos. ....ds.

(Signed) Curtis Rudd M. D.
7/17 1920 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: July 17 1920

20. UNDERTAKER — ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

W. Campbell

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31180

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Franklin

City of Preston

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. ..... St.)

2. FULL NAME Lila Yanis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fmale

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Feb. (Month) 27 (Day) 19 (Year)

7. AGE: 1 Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. Yanis

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lavia Yanis

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. D. Davis

(Address) Preston

15.

Filed ..... 19 .....

D. A. Rudd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 18 1920 that I last saw h.s alive on July 18 1920 and that death occurred on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) ..... Yrs. ..... mos. 30 ds.

Contributory (Secondary) Convulsions

(Duration) ..... yrs. ..... mos. 2 hours ds.

(Signed) L. A. Russell M. D.

July 19 20 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston

DATE OF BURIAL: 7/21 19 20

20. UNDERTAKER: C. A. Lundgren

ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31181

1. PLACE OF DEATH
County of Franklin
City of Weston
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	

6. DATE OF BIRTH
June (Month) 7 (Day) 1920 (Year)

7. AGE
Yrs. Mos. ds.
IF LESS than 1 day how many 6 hrs. or 15 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Roy O. Nelson

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Maria Jensen

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy O Nelson
(Address) Weston Idaho

15.
Filed 19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 7 1920, to June 7 1920 that I last saw her alive on June 7 1920, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Adelectasis - from premature birth
(Duration) - Yrs. - mos. 6 hrs ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) G W States M. D.
June 8 1920 (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Weston — DATE OF BURIAL 6/8 1920

20. UNDERTAKER G. A. Lundquist — ADDRESS Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31182

1. PLACE OF DEATH
County of Franklin
City of Riverdale
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. ..... St.)
Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lynn Shumway Neeley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: July (Month) 25 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Clarence Neeley

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Hattie Shumway

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lyman Neeley
(Address) Riverdale

15. Filed ..... 19..... D. L. R. Cullon
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1920 to July 26 1920 that I last saw h. alive on July 25 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. L. R. Cullon M. D.
19..... (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverdale, Ida. | DATE OF BURIAL: 7/26 1920

20. UNDERTAKER: J. A. Lindquist | ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. Curtis Sr.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31183
Registered No.

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

2. FULL NAME Mary Ethel Seamons
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept 1st (Month) (Day) 1885 (Year)

7. AGE: 34 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jas. N. Shaffer

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Esther A. Jessop

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. M. Seamons
(Address) Preston Idaho

15. Filed 7/15 1920
Dr. A. Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1920, to July 15 1920, that I last saw her alive on July 14 1920, and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Valvular insufficiency and dilatation of heart.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Allen A. Curtis M. D.
19 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death
Former or usual residence Preston

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: 7/16 1920

20. UNDERTAKER: G. A. Lundquist
ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31184

1. PLACE OF DEATH
County of Franklin
City of Weston
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Infant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 24 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 1 hrs. or 0 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph Smith

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nellie Gilbert

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Smith
(Address) Weston Idaho

15. Filed July 26 1920 D. A. R. Cutler Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1920, to July 24 1920, that I last saw him alive on July 24 1920, and that death occurred on the date stated above, at 7 20 M.

The CAUSE OF DEATH* was as follows:
Asphyxiation due to slow birth with cord twisted tightly about its neck
(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Curtis Bland M. D.
7/25 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview Idaho
DATE OF BURIAL: 7/25 1920

20. UNDERTAKER: Mann
ADDRESS: ✓

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31185

Registered No.

1. PLACE OF DEATH

Registration District No.

Primary Registration District No.

County of Franklin

City of Preston (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Apr 11 (Month) (Day) 1872 (Year)

7. AGE: Yrs. 47 Mos. 11 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Preston

10. NAME OF FATHER O. N. Jensen

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Malvina Hansen

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. N. Jensen

(Address) Preston, Idaho

15. Filed Aug 9 1920 Dan Cutler Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9th 1920, to July 22 1920, that I last saw her alive on July 22 1920, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
Whooping Cough

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Allen L. Curtis M. D.

19 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: July 25 1920

20. UNDERTAKER: C. A. Lundquist — ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31186
Registered No.

1. PLACE OF DEATH
County of Bueda
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Hawkes

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write one word.)

6. DATE OF BIRTH: Nov (Month) 22 (Day) 1839 (Year)

7. AGE: 80 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: John Lewis

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Hawkes
(Address) Preston Ida.

15.
Filed 19
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1920, to Aug 5 1920
that I last saw her alive on Aug 4 1920
and that death occurred on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:
Bronchio pneumonia

(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary) Senile debility
(Duration) — yrs. — mos. — ds.

(Signed) G W States M. D.
Aug 7 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Franklin Ida. | DATE OF BURIAL: Aug 8 1920

20. UNDERTAKER: L. A. Sandquist | ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31187
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St. Anthony
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 94
Primary Registration District No. 2 17

2. FULL NAME not named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 21 (Day) 1920 (Year)

7. AGE: ... Yrs. 00 Mos. 00 ds.
IF LESS than 1 day how many 3 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Carlos Briggs

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Florence Davis

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carlos Briggs
(Address) St Anthony Ida

15. Filed June 11 1920 W Burk Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 21 (Day) 1920 (Year).

17. I HEREBY CERTIFY, That I attended deceased from May 21 1920 to May 21 1920.
that I last saw her, alive on May 21 1920.
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J Frank Walkus M. D.
May 21 1920 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Teton Ida
DATE OF BURIAL: May 23 1920

20. UNDERTAKER: —
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
(No. .... St.)
File No. 31188
Registered No. .....

1. PLACE OF DEATH.
County of Freemont
City of St Anthony
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Woodrow Marble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 8 (Day) 1903 (Year)

7. AGE: 6 Yrs. 7 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... None
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER Athemer Marble

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Rose Darrell

13. BIRTHPLACE OF MOTHER (State or Country) Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C C Burt
(Address) St Anthony Ida

15. Filed June 9 1911 C C Burt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 26 (Day) 1911 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~1911~~ ....., to ~~.....~~ 191....., ~~that I last saw h alive on~~ ~~.....~~ 191....., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
drowned in Canal

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) C C Burt M. D.
19..... (Address) St Anthony Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parker — DATE OF BURIAL: May 30 1911

20. UNDERTAKER: Wm Hansen — ADDRESS: St Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

AVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 31189
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nephi Vanderby

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married

6. DATE OF BIRTH: May (Month) 7 (Day) 1848 (Year)

7. AGE: 72 Yrs. 1 Mos. 20 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Nicholas Vanderby

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Ruff

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cora Everett
(Address) Parker, Idaho

15. Filed July 10 1922 — W Dark, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to June 29 1920
that I last saw him alive on June 28 1920
and that death occurred on the date stated above, at 9:30 A.M.
The CAUSE OF DEATH* was as follows: Pernicious Interstitial Nephritis

(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary): Myocarditis
(Duration) 1 yrs. ..... mos. ..... ds.
(Signed) J E Melton M. D.
6-30 1920 (Address) St Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parker, Idaho — DATE OF BURIAL: 7-1 1920

20. UNDERTAKER: Taylor-Ellison Undertaking Co. — ADDRESS: St Anthony Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 31190
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St. Anthony
(No. , Street)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Trude

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 6 (Month) 7 (Day) 1920 (Year)

7. AGE: ....Yrs. ....Mos. 8 ds.
IF LESS than 1 day: how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Leo Trude

11. BIRTHPLACE OF FATHER (State or Country): ~~Idaho~~ South Dakota Ranchman

12. MAIDEN NAME OF MOTHER: Minnie Fisher

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo Trude
(Address) St Anthony

15. Filed July 10 1920 W Reed Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 30 1920, to June 7 1920 that I last saw h alive on June 6 1920 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Exhaustion due to
Premature birth
(Duration) ....Yrs. ....mos. 7 ds.
Contributory (Secondary): none
(Duration) ....yrs. ....mos. ....ds.

(Signed) J. M. Kay M. D.
6/7 1920 (Address) St Anthony

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: St Anthony
DATE OF BURIAL: 6/7 1920

20. UNDERTAKER: Taylor
ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31191
Registered No. .....

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Fremont
City of Drummond

2. FULL NAME Baby Caldwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 7 (Month) 1 (Day) 1920 (Year)

7. AGE ..... Yrs. 21 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Chas Caldwell

11. BIRTHPLACE OF FATHER (State or Country) Neb

12. MAIDEN NAME OF MOTHER Nellie Davis

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Caldwell
(Address) Drummond Idaho

15. Filed 7/23/20 E. M. Meacham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 7 (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/11, 1920 to ..... 191..., that I last saw h[illegible] alive on 7-23 1920 and that death occured on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Premature

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature birth

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. M. Meacham M. D.

7/23 1920 (Address) Preston Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pine View Cemetery Ashton Idaho
DATE OF BURIAL 7-24 1920

20. UNDERTAKER Lewis Kiser
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STEIN - YORK CO., PTRS. & STNRS. 24854

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31192
Registered No.

1. PLACE OF DEATH.
County of Gem
City of Emmett
(No. ....., ... St.)
Registration District No. 6
Primary Registration District No. 1010
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Margaret Jane Dawes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: September 16 (Month) (Day) 1841 (Year)

7. AGE: 78 yrs. 10 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico, Missouri USA

10. NAME OF FATHER: Joseph Crockett

11. BIRTHPLACE OF FATHER (State or Country): Lexington, Kentucky

12. MAIDEN NAME OF MOTHER: Nancy Knight

13. BIRTHPLACE OF MOTHER (State or Country): Nashville, Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. B. Polly
(Address) Emmett, Idaho

15. Filed 7/19 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1919, to July 18 1920, that I last saw her alive on July 18 1920, and that death occurred on the date stated above, at 1:30 a M.

The CAUSE OF DEATH* was as follows:

Senile Decay Paralysis

(Duration) yrs. 7 mos. 28 ds.

Contributory (Secondary): Age 78 yrs

(Duration) yrs. mos. ds.

(Signed) C. B. Polly M. D.
July 18 1920 (Address) Emmett Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Mont. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: C. D. Buckman ADDRESS: Emmett

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31193

Registered No. .....

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Gem
City of Emmett
(No. ....., ... St.)

Registration District No. 6
Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sidney Frances Sherard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 5 (Day) 1883 (Year)

7. AGE: 36 yrs. 11 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Sidney Kingman

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Jennie Dobbs

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burt S Sherard
(Address) Emmett Idaho

15.
Filed 8/2 1911 J. A. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1911 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1907, to July 1911, that I last saw h[er] alive on July 8 1911, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis Kidney and bowels

(Duration) 15 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Reynolds M. D.
19 ..... (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: July 11 1911

20. UNDERTAKER: O. L. Bucknum
ADDRESS: Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1020
Primary Registration District No. 6
(No. ....., ... St.)

File No. 31194
Registered No. .....
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Frank A. De Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Mar (Month) 13 (Day) 1863 (Year)

7. AGE: 57 yrs. 4 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: James B. De Clark

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Amelia Stoddard

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Une Skinner
(Address) Emmett Idaho

15.
Filed 8/2/1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1920, to July 31 1920
that I last saw him alive on July 31 1920
and that death occurred on the date stated above, at 23 a.m.

The CAUSE OF DEATH* was as follows:
Hemorrhage internal
following accident of
July 27.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Burton O'Clark M. D.
Aug 2nd 1920 (Address) Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds
In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: Aug 1 1920

20. UNDERTAKER: C. D. Buckmum
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31195
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mary Louise Rivord

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: July (Month) 8 (Day) 1920 (Year)

7. AGE: — yrs. — mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Infant
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Antone Rivord

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Nettie Durache

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Antone Rivord
(Address) Emmett Ida

15.
Filed Aug 4 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1920, to Aug 2 1920, that I last saw h-e-r alive on July 1 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Imbition —

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.
8/4/1920 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 8/3 1920

20. UNDERTAKER: C. D. Buckman
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18872

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31196
Registered No.

1. PLACE OF DEATH.
County of Gem
City of Emmett
(No. , St.)
Registration District No. 201
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME John Meyer Nyborg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: Apr 18 (Month) 1880 (Day) 1 (Year)

7. AGE: 40 yrs. 3 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Lumberman
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Lars Nyborg

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hilma Nyborg
(Address) Emmett Idaho

15.
Filed July 21 1921
J. L. Reynolds Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1920 to July 29 1920 that I last saw h[illegible] alive on July 29 1920 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

[illegible]

(Duration) 1 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

July 29 1920 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida
DATE OF BURIAL: 7/31 1920

20. UNDERTAKER: C. D. Buckmun
ADDRESS: Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 711
Primary Registration District No.
(No. , St.)
File No. 31197
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph H. Brook
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Sept (Month) 6 (Day) 1860 (Year)

7. AGE: 59 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hotel Proprietor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Talley
(Address) Sweet Idaho

15. Filed 8/14 1920 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920 to Aug 11 1920 that I last saw him alive on Aug. 9 1920 and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Neoplasm of Lung
(Duration) unknown yrs. mos. ds.
Contributory (Secondary) Hemorrhage
(Duration) Half an hour yrs. mos. ds.
(Signed) Austin G. Rush M. D.
9/12 1920 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Louis Mo | DATE OF BURIAL 19

20. UNDERTAKER: C. D. Bucknum | ADDRESS Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 210
Primary Registration District No. 210
File No. 31198
(No. ..... St.)
Registered No. .....

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Augusta Hansen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Oct (Month) 29 (Day) 1846 (Year)

7. AGE: 79 Yrs. 9 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Hans Christensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): " -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chris Hansen
(Address) Emmett Idaho

15. Filed Aug 10 1920 J. L. Reynolds Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Several years, to Date of death 1920 that I last saw h... alive on Aug 7 — 1920, and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Causing Uremia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. L. Reynolds M. D.
8/10 1920 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 8/10 1920
20. UNDERTAKER: O. Buckman
ADDRESS: Emmett Idaho

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2010
Primary Registration District No.
File No. 31199
Registered No.

1. PLACE OF DEATH.
County of Ada
City of Emmett
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Regina Imogene Wells

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Jan (Month) 23 (Day) 1905 (Year)

7. AGE: 15 yrs. 5 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: student
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: E. F. Wells

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Frances Elwood

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. F. Wells
(Address) Emmett Idaho

15. Filed 9/7 1911 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 5 (Day) 1911 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 4 1911, to July 5 1911, that I last saw her alive on July 4 1911, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Diabetis Mellitus

(Duration) 3 yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. L. Reynolds M. D.
9/7 1911 (Address) Emmett

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Smith Center Kan
DATE OF BURIAL: 191

20. UNDERTAKER: C. D. Buckman
ADDRESS: Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. [redacted]0-11.

[redacted]IFICATE OF DEATH

State of [redacted] BOARD OF [redacted]H
Bureau of Vital [redacted]tics
File No. 31201

1. PLACE OF DEA[redacted] Registration District No. 6
County of Gem Primary Registration District No. 10W
City of Emmett (No. 6, St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Edson Bishop

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: not known (Month) 1 (Day) (Year)

7. AGE: 70 yrs. mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John Bishop

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Elizabeth Cupid

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed Bishop
(Address) Emmett Ida

15.
Filed July 16 1920 J. K. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

No doctor in attendance

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Falk Idaho
DATE OF BURIAL: 7/17 1920

20. UNDERTAKER: O. D. Buckmun
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 18672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31202

Registered No.

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1014
(No. , St.)

2. FULL NAME Charles Junior Hargis

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April 1 1920 (Month) (Day) (Year)

7. AGE: yrs. 3 mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho, Gooding

10. NAME OF FATHER: Charles Hargis

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Gale Boone

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Hargis
(Address) Gooding

15.
Filed Aug 4 1920
F J Caymond
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1920, to July 10 1920 that I last saw him alive on July 10 1920, and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:—
acute inanition
and heat exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F C Caymond M. D.
July 10 1920 (Address) Gooding Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place ..... In the
of death ..... yrs. ..... mos. ..... ds. State ..... yrs. ..... mos. ..... ds.
Where was Disease contracted,
If not at place of death? .....
Former or
usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding
DATE OF BURIAL: 191

20. UNDERTAKER: A E Thompson
ADDRESS: Gooding, Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 231203

Registered No. .....

1. PLACE OF DEATH.

County of Idaho

City of Kenteroville

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence Leonard Uhling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July 12 1918 (Month) (Day) (Year)

7. AGE: 2 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Lorenz Uhling

11. BIRTHPLACE OF FATHER (State or Country) Minn

12. MAIDEN NAME OF MOTHER Jessie Doty

13. BIRTHPLACE OF MOTHER (State or Country) Wash

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lorenz Uhling

(Address) Kenteroville

15. Filed July 30 1920 H B Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1920, to July 29 1920, that I last saw him alive on July 29 1920, and that death occured on the date stated above, at 11.50 P.M.

The CAUSE OF DEATH* was as follows:

Accidental from injuries Jolting being run over by Auto-truck

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) H B Blake M. D.

7/30 1920 (Address) Cottonwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kenteroville Idaho

DATE OF BURIAL: July 30 1920

20. UNDERTAKER: Nau

ADDRESS: Cottonwood Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & SDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31204

Registered No. .....

Registration District No. 49

Primary Registration District No. 2928

(No. ..... St.)

1. PLACE OF DEATH.

County of Idaho

City of near Kamiah Ida

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leona Wells

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 5 (Day) 1911 (Year)

7. AGE: 9 Yrs. 3 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Julius Wells

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Martha Wigner

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. F. Wallis

(Address) Kamiah Idaho

15. Filed 8/3 1920

J. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw her alive on Aug 4 1920

and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Diphtheria

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19..... (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boot Cem. Kamiah Idaho — DATE OF BURIAL: 8/4 1920

20. UNDERTAKER: J. J. Johnson — ADDRESS: Kamiah Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Kooskia
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 106
Primary Registration District No. 2184
(No. ....., ... St.)

File No. 31205
Registered No. 95
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Vernon Toll

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
June (Month) 24 (Day) 1920 (Year)

7. AGE
..... yrs. ..... mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant -
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Willard Toll

11. BIRTHPLACE OF FATHER
(State or Country) Illinois

12. MAIDEN NAME OF MOTHER Daisy Graham

13. BIRTHPLACE OF MOTHER
(State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willard Toll
(Address) Kooskia - Idaho

15.
Filed July 10 1920 J. W. Robertson
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 24 1920 to July 9 1920
that I last saw him alive on June 24 1920
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature birth - (7 mos)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Tahoe Cemetery — DATE OF BURIAL: July 10 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19. Amended Item #2,6,9,10-13 6-2-03 LME

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 422
Primary Registration District No. 2204
File No. 3A206
Registered No. 21

1. PLACE OF DEATH
County of Fremont
City of Drigston (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Elmer McDowell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: August (Month) 19 (Day) 1894 (Year)

7. AGE: 26 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Montana - Missouri

10. NAME OF FATHER: John M. McDowell

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Sarah Lux Ruth Archer

13. BIRTHPLACE OF MOTHER (State or Country): ~~Ill~~ Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. N. Archer
(Address) Drigston

15. Filed Aug 1 1920 J. N. Archer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1920 to July 2 1920 that I last saw h— alive on July 2 1920 and that death occurred on the date stated above, at 3P M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
Pneumonia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. N. Archer M. D.
July 3 1920 (Address) Harrison Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 12 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida — DATE OF BURIAL: July 3 1920

20. UNDERTAKER: R. B. Mooney — ADDRESS: Coeur d'Alene

IDAHO DEPARTMENT OF HEALTH AND WELFARE
BUREAU OF VITAL RECORDS AND HEALTH STATISTICS

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of Idaho
County of Ada } SS.

Certificate No. 20-31206
Date Filed 8-1-20

The undersigned does solemnly swear that certain facts on the certificate of death (Birth, Death, Marriage, etc.)

for Elmer McDowell (Name on Original Certificate) who died (Was Born, Died, etc.) on July 2, 1920 (Date of Event)

in Springston (Kootenai) Idaho (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
#2 Full Name	Elmer McDowell	James Elmer McDowell
#6 Date of Birth	Unknown	August 19, 1894
#9 Birthplace	Montana	Missouri
#10 Name of Father	McDowell	John M. McDowell
#11 Father's Birthplace	Unknown	Kansas
#12 Mother's Maiden Name	Ruth Archer	Sarah Lux
#13 Mother's Birthplace	Illinois	Missouri

Subscribed and sworn to before me this 2nd day of June, 2003.

Notary Public, Linda Marlene Elampaw

Residing at Boise Ada Idaho

My commission expires 11-16-05
(Seal)

James T. McDowell
Signature of Applicant

27250 Murrieta Road Space 63
Sun City, CA 92586
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____
County of _____ } SS.

(Must be completed ____)
(Is not necessary X)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____, _____.

Notary Public, _____

Residing at _____

My commission expires _____
(Seal)

_____
Supporting Signature

_____
Street Address, City, State

Newspaper Article regarding John McDowell's wife died on November 7, states wife's name as Lux (as brother's name was James H. Lux. Viewed by VS

Newspaper article regarding Wife of John McDowell (James Elmer McDowell's mother) as stated in article - 5 children born and living and states his name. Viewed by VS

Ancestry - Individual Database Search Results for James Elmer McDowell birthdate 8-19-1894 born in Kansas City, Missouri. Viewed by VS

Marriage Record Index states Elmer McDowell was married to Ruth Archer on 12-23-1913 in Coeur d Alene (Kootenai) Idaho. Viewed by VS

Census Population Record for Montana 5th day of June 1900 states Johnny McDowell - Head of Household, Wife Sarah, sibling's Pearl, Mary, John, James born 1894, and Everett. Viewed by VS States father born in Kentucky.

States in newspaper article Sarah was born in Missouri and her maiden name was Lux.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31207

Registered No. 62

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

Registration District No. 126

Primary Registration District No. 2204

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Maxine Craine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 7 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Harrison Idaho

10. NAME OF FATHER Oscar M. Craine

11. BIRTHPLACE OF FATHER (State or Country) Wis

12. MAIDEN NAME OF MOTHER Pearl Funk

13. BIRTHPLACE OF MOTHER (State or Country) Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Oscar M. Craine

(Address) .....

15. Filed Aug 1 1920

J. M. Timmons
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1920, to July 12 1920, that I last saw her alive on July 12 1920, and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Pertussis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Timmons M. D.

7-13 1920 (Address) Harrison

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison Ida. | DATE OF BURIAL: 7-13 1920

20. UNDERTAKER: Stone | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
File No. 21208
Registered No. 43

1. PLACE OF DEATH.
County of Kootenai
City of Harrison
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo W Moss.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) (Day) 1857 (Year)

7. AGE: 63 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Business
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Jake Moss

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Jones

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Tom Jarrett
(Address) .....

15. Filed 7-18 1920 [illegible] Local Registrar

SYMS - YORK CO., PTRS. & SDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13, 1920, to July 16 1920, that I last saw him alive on July 18 1920, and that death occured on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Kinney M. D.
7-18 1920 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Lake — DATE OF BURIAL: 7-19 1920

20. UNDERTAKER: C. Cassedy — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 5120
Registered No. 11

1. PLACE OF DEATH
County of Kootenai
City of Near Worley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 46
Primary Registration District No. 2172
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Davis Straight

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married

6. DATE OF BIRTH. June (Month) 11 (Day) 1844 (Year)

7. AGE 76 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York State

10. NAME OF FATHER Davis Straight

11. BIRTHPLACE OF FATHER (State or Country) New York State.

12. MAIDEN NAME OF MOTHER Abago Genson.

13. BIRTHPLACE OF MOTHER (State or Country) New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Plummer Idaho

15. Filed July 16 1920 ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1920 to July 12 1920 that I last saw him alive on July 12 1920 and that death occurred on the date stated above, at 6.30 A. M.

The CAUSE OF DEATH* was as follows:
Myocardiab degeneration
.....
.....
Several (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Death due to exertion of dressing
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Claude A. Lewis M. D.
7-14-1920 (Address) Fairfield Wash.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence Was born in Pennsylvania. Came to Idaho Resided for two years.

19. PLACE OF BURIAL OR REMOVAL Worley Idaho. DATE OF BURIAL July 16 1920

20. UNDERTAKER ..... ADDRESS Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Coeur D Alene

Registration District No. 30

Primary Registration District No. 1051.

(No. Coeur D Alene Hosp St.)

File No. 31211

Registered No. 829.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marvel Hurst

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: March (Month) 26 (Day) 1900 (Year)

7. AGE: 20 Yrs. 3 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Mayfield

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tom Pidcock

(Address) Coeur d'Alene Ida

15. Filed Aug 4 1920 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1920 to July 20 1920 that I last saw her alive on July 20 1920 and that death occurred on the date stated above, at 12 30 M.

The CAUSE OF DEATH* was as follows:

Septicemia.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Drennan M. D.

7/22 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 15 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: July 23 1920

20. UNDERTAKER: [illegible] Toomey — ADDRESS: Cda. Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Coeur D Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38

Primary Registration District No. 1051

(No. City Park St.)

File No. 31213

Registered No. 827

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Savage

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	white	Single (Write the word.)

6. DATE OF BIRTH

Unknown (Month) 1 (Day) (Year)

7. AGE About 40 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Prop. Dance Hall

(b) General nature of industry, business or establishment in which employed (or employer) Kellogg, Ida.

9. BIRTHPLACE (State or Country) Unknow Austria

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Micheal Savage

(Address) Kellogg, Ida

15. Filed Aug 4 1920 L D Dressel Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 18, 1920 (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1920, to July 18 1920 that I last saw h alive on 19, and that death occurred on the date stated above, at 2 8 M.

The CAUSE OF DEATH* was as follows:

Cor Pleurae adhesions

Crushed internally

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L. D. Dressel M. D.

7/19 1920 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Kellogg, Ida.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg, Ida	7/21-1920

20. UNDERTAKER ADDRESS

T B Mooney Coeur d'Alene, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1037
File No. 31214
Registered No. 826

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. ..... City Park ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stephen E Miller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March (Month) 24 (Day) 1895 (Year)

7. AGE: 24 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Pilot
(b) General nature of industry, business or establishment in which employed (or employer): Maxwell Aviation Co

9. BIRTHPLACE (State or Country): Pullman Wn

10. NAME OF FATHER: Levi Miller

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Jennie Cameron

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E C Miller
(Address) Pullman Wn

15. Filed Aug 4 1920 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:
Aeroplane accident
Crushed internally
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. D. Drennan M. D.
7/18 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 16 days
Where was disease contracted if not at place of death?
Former or usual residence Pullman Wn

19. PLACE OF BURIAL OR REMOVAL: Pullman Wn
DATE OF BURIAL: July 19 1920

20. UNDERTAKER: R S Mooney
ADDRESS: Coeur d'Alene Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 31215
Registered No. 826

1. PLACE OF DEATH

County of Kootenai
City of Coeur D Alene
(No. Post Falls St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME ~~J. A. Stover~~ I. Wallace Stover

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: About 68 Yrs. 55 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Engineer
(b) General nature of industry, business or establishment in which employed (or employer): Post Falls, Ida. Rube dew Lumber Co

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Eva Booth
(Address) Boise, Ida.

15. Filed Aug. 4 1920 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21/20 (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....
that I last saw h.... alive on ....19....
and that death occurred on the date stated above, at 8P M.
The CAUSE OF DEATH* was as follows:
Probable Cause - Apoplexy
Died Suddenly and was not seen by physician before death.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) [signature] M. D.
7/26 19 21 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. 1 mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: July 23 1920

20. UNDERTAKER: R B Mooney
ADDRESS: Coeur d Alene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31217
Registered No. .....

1. PLACE OF DEATH
County of ~~Shoshone~~ Kootenai
Registration District No. .....
Primary Registration District No. .....
City of Coeur d'Alene (No. 4th St., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Geo Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	Caucasian White	Married

6. DATE OF BIRTH. ..... 1..... (Month) (Day) (Year)

7. AGE 56 Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Missouri

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Missouri

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Beryle A. Fiske
(Address) Spokane, Wash.

15. Filed 7/31 1920 Geo. D. Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191..
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....,....M.
The CAUSE OF DEATH* was as follows:
Auto Accident
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) Geo. D. Lesher M. D.
7/31 1920 (Address) Kellogg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Spokane Wash. DATE OF BURIAL July 31 1920

20. UNDERTAKER M. F. Nordlund ADDRESS Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 31218
Registered No. 824

1. PLACE OF DEATH

County of Kootenai
City of Coeur D Alene (No. 410, Third St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bernice Josephine Brandvold

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 9 (Day) 1920 (Year)

7. AGE: 0 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ingvold Brandvold

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Bernice J Shramek

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ingvold Brandvold
(Address) Coeur D Alene

15. Filed Aug 4 1920 D D Brennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1920 to July 26 1920 that I last saw h.e.r. alive on July 25 1920, and that death occurred on the date stated above, at 0 A. M.
The CAUSE OF DEATH* was as follows:

Acute Gastrointestinal catarrh with Meningeal involvement
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H C Fuqua M. D.
July 26 1920 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. 3 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Thomas Cemeterey
DATE OF BURIAL: 7 28 1920

20. UNDERTAKER: R. B. Mooney
ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31220

Registered No. 106

1. PLACE OF DEATH

County of Latah

City of Moscow (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geraldine Rose Swecker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: April (Month) 20 (Day) 1920 (Year)

7. AGE: ..... Yrs. 2 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: John H. Swecker.

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Ava Byers.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John H. Swecker

(Address) Moscow

15. Filed July 11 1920 W. H. Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Haemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... Coroner

7/11 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 7/11 1920

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 31221
Registered No. 104

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Michael Franklyn Zeigler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: August (Month) 20 (Day) 1847 (Year)

7. AGE: 72 Yrs. 10 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor & Builder
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Michael Zeigler

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Not known here

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leroy Zeigler
(Address) Moscow

15. Filed 7/12 1920 W. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1920 to July 11 1920, that I last saw him alive on July 9 1920, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Endocarditis Chronic

(Duration) Long about Yrs. mos. ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration) Don't Know Yrs. mos. ds.

(Signed) J. H. Clarke M. D.
7/12 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 7/15 1920

20. UNDERTAKER: [illegible]
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 31222
Registered No. 108

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dora Belle Oyler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Single

6. DATE OF BIRTH: Jan (Month) 25 (Day) 1902 (Year)

7. AGE: 18 Yrs. 5 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary Holmes

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary Oyler
(Address) Moscow Ida

15. Filed 7/16 1920 N. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 6 1920, to July 11 1920, that I last saw her alive on July 11 1920, and that death occurred on the date stated above, at 12 P.M.
The CAUSE OF DEATH* was as follows:
Acute interstitial nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. L. Gritman M. D.
7/16 1920 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	7/17 1920

20. UNDERTAKER: Palouse Undertaking Co. ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... St.)

File No. 31223
Registered No. 182

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Belle Decker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 15 (Day) 1865 (Year)

7. AGE: 54 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hausz wife,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois,

10. NAME OF FATHER: James McGrew

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Mary Moore

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed July 26 1920 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 11" 1920, to July 25" 1920, that I last saw h.er alive on July 24" 1920, and that death occurred on the date stated above, at 12-" M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis.
(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. H. Carithers M. D.
7/26 1920 (Address) Moscow, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: July 28 1920

20. UNDERTAKER: [illegible] | ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31224
Registered No. 110

1. PLACE OF DEATH. Registration District No. 361
County of Latah Primary Registration District No. 2141
City of Farmington (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Sibert

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	

6. DATE OF BIRTH: July (Month) 9 (Day) 1920 (Year)

7. AGE: 1 yrs. ..... mos. ..... ds. IF LESS than 1 day how many 20 hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Latah Co.

10. NAME OF FATHER J. W. Sibert

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Nellie Wiseman

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Sibert
(Address) Farmington Wash

15. Filed 7-14-20 D. H. Carruthers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 1920, to July 10 1920
that I last saw her alive on July 10 1920
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Atelectasis Neonatorum
Premature birth

(Duration) ..... yrs. ..... mos. 20 hrs.

Contributory (Secondary) Prematurity

— (Duration) — yrs. — mos. — ds.

(Signed) W. C. Brandon M. D.
7-11-1920 (Address) Garfield Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Farmington Wash — DATE OF BURIAL: July 11 1920

20. UNDERTAKER: F. L. Swims — ADDRESS: Garfield, Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
File No. 31225
Registered No.

1. PLACE OF DEATH

County of
City of
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Boursassa

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Dec. (Month) 29 (Day) 1851 (Year)

7. AGE: 68 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Richard Jones

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary Evans

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe Boursassa
(Address) Potlatch, Idaho

15.
Filed July 31 1920
J. W. Thompson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1st 1919, to December 29 1919, that I last saw her alive on December 29 1919, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of the uterus

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. E. Fortman M. D.

7/27/1920 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 9 yrs. mos. days. In the State 9 yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Potlatch, Idaho — DATE OF BURIAL: July 27 1920

20. UNDERTAKER: Husband — ADDRESS: Potlatch, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Potlatch

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... , ... St.)

File No. 31226

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isaac Reese Harrison

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: January (Month) 30 (Day) 1856 (Year)

7. AGE: 64 Yrs. 6 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer): lumber Business

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Wm D. Harrison

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Tryphena Reese

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice Harrison

(Address) Potlatch, Idaho

15. Filed July 30 1920 T. W. Thompson Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1920 to July 30 1920 that I last saw h.im. alive on July 28 1920 and that death occurred on the date stated above, at 5.25 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate gland
Metastisis to liver, stomach and mesenteric glands

(Duration) Yrs. 9 mos. ..... ds.

Contributory (Secondary) Cachexia and anaemia

(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) Paul J. Fewrs M. D.

July 30 1920 (Address) Potlatch, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 10 yrs. — mos. — days. In the State 10 yrs. — mos. — days

Where was disease contracted if not at place of death? —

Former or usual residence Potlatch, Idaho

19. PLACE OF BURIAL OR REMOVAL: H. H. Irwin — DATE OF BURIAL: Aug 2 1920

20. UNDERTAKER: Spokane, Wash — ADDRESS: Palouse

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31227
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Linden
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 68
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs Lou A Fonberg.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: April (Month) 11 (Day) 1876 (Year)

7. AGE: 44 yrs. 3 mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Sam McKey

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Dialtha Leamaster

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Fonberg
(Address) Linden Idaho

15. Filed 7-28 1920 R. F. Pepple, Local Registrar
Juliaetta Ida

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1st 1920, to July 24 1920
that I last saw her alive on July 24 1920
and that death occurred on the date stated above, at 7.15 P M.

The CAUSE OF DEATH* was as follows:

Acute Bright's Disease

(Duration) yrs. mos. 10 ds.
Contributory (Secondary) Chronic Bright's Disease
(Duration) 1 yrs. 2 mos. ds.

(Signed) W. A. Rothwell M. D.
July 28 1920 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Linden Cemetery
DATE OF BURIAL: July 29 1920

20. UNDERTAKER: Elmer Bechtol
ADDRESS: Kendrick Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. WRITE PLAINLY, WITH UNFADING INK. Exact CIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. ment of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2116
File No. 31228
Registered No. ____

1. PLACE OF DEATH.
County of Lemhi
City of Salmon, (No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George A. MacDonald
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March (Month) 16 (Day) 1875 (Year)

7. AGE: 45 Yrs. 4 Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): Mining

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Peter MacDonald

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Elizabeth McPhee

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. S. Dewis
(Address) Baker Idaho

15. Filed 7/19 1920 Leola Nodding Deputy Local Registrar

SVMB - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1920, to July 16 1920, that I last saw him alive on July 16 1920 and that death occured on the date stated above, at 2.00 P.M.

The CAUSE OF DEATH* was as follows:
General peritonitis
following injury
fire logging accident
(Duration) ____ Yrs. ____ mos. 2 ds.

Contributory (Secondary) ____ (Duration) ____ yrs. ____ mos. ____ ds.

7/17 1920 (Signed) C. S. Patton M. D.
(Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs ____ mos ____ days. In the State ____ yrs ____ mos ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Milford Station Ns. DATE OF BURIAL: ____ 191____

20. UNDERTAKER: W. C. Doebler ADDRESS: Salmon Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 47
Primary Registration District No.
File No. 31229
Registered No. 59

1. PLACE OF DEATH.
County of Lewis
City of Nezperce
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Helen McCaldwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. June 18 (Month) (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: infant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nezperce Idaho

10. NAME OF FATHER: G. W. Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Julia Rennebeck

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G W Mitchell
(Address) Nezperce Idaho

15. Filed 8-20 1920 Albert Huff Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1920, to Aug 10 1920, that I last saw h- alive on aug 9 1920, and that death occured on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) Yrs. mos. 21 ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) R E Dunevale M. D.

8/10 1920 (Address) Fairground Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce Cemetery
DATE OF BURIAL: 8-10 1920

20. UNDERTAKER: Albert Huff
ADDRESS: Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 16
Primary Registration District No. 1016

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31230
Registered No. .....

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pablo Arriaga

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. August 14 1919
(Month) (Day) (Year)

7. AGE: 1 Yrs. 2 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country) Utah

10. NAME OF FATHER: Nicolas Arriaga

11. BIRTHPLACE OF FATHER
(State or Country) Mexico

12. MAIDEN NAME OF MOTHER: Adalana Jimenez

13. BIRTHPLACE OF MOTHER
(State or Country) Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Pablo Arriaga
(Address) Shoshone

15. Filed July 31 1920
J. L. Fuller
Local Registrar

SYMS-YORK CO., PTRS. DENVER 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 30 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1920 to July 30 1920, that I last saw h— alive on July 22 1920 and that death occured on the date stated above, at 12.45 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia
.....
.....
.....
(Duration) 1 Yrs. 11 mos. ..... ds.

Contributory (Secondary) Lues
(Duration ..... yrs. 11 mos. ..... ds.

July 31 1920 (Signed) [illegible] M. D.
(Address) Shoshone Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone
DATE OF BURIAL: 7-31 1920

20. UNDERTAKER: J. F. Brennan
ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2016
File No. 31231
Registered No. 24

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Manuel Inzar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. April 12 1847
(Month) (Day) (Year)

7. AGE: 73 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Azore Islands

10. NAME OF FATHER: Manuel Inzar

11. BIRTHPLACE OF FATHER (State or Country): Azore Island Pico

12. MAIDEN NAME OF MOTHER: Mary Fraguina

13. BIRTHPLACE OF MOTHER (State or Country): Azore Island

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joe Inzar
(Address) Shoshone

15. Filed July 26 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July 25 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ July 22 1920, to ..... 191..., that I last saw h. alive on July 22 1920, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Phthisis
(Duration) many Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Jones M. D.
19..... (Address) Shoshone

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone Idaho — DATE OF BURIAL: 7-28-1920

20. UNDERTAKER: O. J. Truman — ADDRESS: Shoshone Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & PUBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 16

Primary Registration District No. 2016

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31232

Registered No. 26

1. PLACE OF DEATH.

County of .....

City of .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis Hosea Roundy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 14 (Day) 1898 (Year)

7. AGE: 22 Yrs. 2 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Weber Co Utah

10. NAME OF FATHER: W. D. Roundy

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake Co Utah

12. MAIDEN NAME OF MOTHER: Merrill

13. BIRTHPLACE OF MOTHER (State or Country): Cedo Washington Co Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) M. E. Roundy
(Address) Moscow Idaho

15. Filed Aug 6 1920

J. L. Fuller
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 6 1920, that I last saw him alive on Aug 6 1920, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Typhoid fever
.....
.....
(Duration) ..... Yrs. ..... mos. 2 1 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Jones M. D.
8/16 1920 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho
DATE OF BURIAL: 191

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31233
Registered No. 72

1. PLACE OF DEATH
County of Madison
City of Sugar
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 217
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: January (Month) 16 (Day) 1906 (Year)

7. AGE: 14 Yrs. 6 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): work at Home

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E. L Evans

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Alice L Partington

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. L Evans
(Address) Sugar city

15. Filed 7/25 20 — G V Espe, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1919 to July 24 1920 that I last saw h[illegible] alive on July 23 1920, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(Duration) 9 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Farley Nelson M. D.
7-26 1920 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: July 26 1920

20. UNDERTAKER: Rexburg Furn Co — John Shillito — ADDRESS: Rexburg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178
(No. ..... St.)

File No. 31234
Registered No. 45
If death occured in a hospital or institution or camp, give name instead of street and number.

2. FULL NAME Rudolph Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH
Jan (Month) 26. (Day) 1838 (Year)

7. AGE
87 yrs. 5 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Shoe Maker
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Switzerland

10. NAME OF FATHER John Miller

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rudolph Miller
(Address) Rigby Ida

15.
Filed 7-8 1920
G L Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 6. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920, to July 6 1920
that I last saw him alive on July 4 1920
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

General debility

(Duration) yrs. 6 mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.
(Signed) G L Parkinson M. D.
19 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rigby	7/8 1920
20. UNDERTAKER	ADDRESS
J H Lyons	Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 31235

Registered No. 47 49

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Briscoe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Oct (Month) 27 (Day) 1850 (Year)

7. AGE: 70 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Dave Rogers

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tim M Briscoe

(Address) Rupert Idaho

15. Filed Aug 6 1920 E A Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920 to April 10 1920 that I last saw h-- alive on April 10 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

8-6 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Aug 13 1920

20. UNDERTAKER: W. G. Henderson — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 31236
Registered No. 48

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arnold Randall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Aug (Month) 8 (Day) 1916 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Harry Randall

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Edna Peck

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Randall
(Address) Rupert Idaho

15. Filed Aug 5 1920 E. H. Elmore, Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Apr. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 27 1920, to Apr 27 1920, that I last saw h[illegible] alive on Apr. 27 1920, and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Burned over most of body
(Duration) ..... Yrs. ..... mos. 5 hrs. ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. H. Elmore M. D.
8-6 1920 (Address) Rupert, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19 .....
Rupert Cemetery	
20. UNDERTAKER W. F. Goodman	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 31237
Registered No. 47

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie B Moore
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: April (Month) 29 (Day) 1869 (Year)

7. AGE: 51 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: James. T. Whiteside

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Cox

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Moore
(Address) Rupert Idaho

15. Filed Aug. 5 1920 E. O. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 19 1920, to Apr. 26 1920, that I last saw her alive on Apr. 26 1920 and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Septicemia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Smallpox Vaccination
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. O. Elmore M. D.
8-5 1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Apr 26 1920
20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2013
(No. ..... St.)

File No. 31238
Registered No. 46

1. PLACE OF DEATH

County of Minidoka
City of Paul

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gerald Wardell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
September (Month) 5 (Day) 1915 (Year)

7. AGE
5 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John B. Wardell

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Isabell Wardell

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John B Wardell
(Address) Paul Idaho

15.
Filed Aug. 3 1920
E. H. Ehmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Feb 25 20
(Month) (Day) 19 ~~20~~ (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 25 19 20 to ..... 19 .....
that I last saw him alive on Feb 25 19 20
and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
accident of home made
died in few minutes
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. E. Ehmore M. D.
Apr 5 19 20 (Address) Paul, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemt.	Feb 25 19 20

20. UNDERTAKER	ADDRESS
W. A. Goodman	Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2013
File No. 31242
Registered No. 42

1. PLACE OF DEATH
County of Minidoka
City of Rupert (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Luigi Bott.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: Dec (Month) 28 (Day) 1878 (Year)

7. AGE: 42 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Robert Bott

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Mary Stinger

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lezafina Bott.
(Address) Rupert Idaho.

15. Filed Aug. 5 1920 E. V. Elsner, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/3 1918, to July 16 1920 that I last saw h~~im~~ alive on 7/16 1920 and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis with probable bronchiectasis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. H. Kerby M. D.
1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	July 18 1920

20. UNDERTAKER	ADDRESS
W. C. Gardner	Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Cuta

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 31243
Registered No. 41

1. PLACE OF DEATH
County of Minidoka
City of Rupert (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Lynn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1857 (Year)

7. AGE: 61 Yrs. 5 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Andrew Lynn

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Kinslow

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Aug. 5 1920 E. V. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mar (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/17 1920, to 3-24 1920
that I last saw h~~im~~ alive on 3-24 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Arteriosclerosis with infarcts in stomach Kidneys and spleen
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. N. Kenyon M. D.
1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Mar 28 1920
20. UNDERTAKER: W. J. Goodman — ADDRESS: Rupert

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31644
Registered No. [illegible]

Registration District No. 19
Primary Registration District No. 2015

1. **PLACE OF DEATH**
County of Minidoka
City of Rupert (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Fred H. Brown.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** male

4. **COLOR OR RACE** white.

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** married (Write the word.)

6. **DATE OF BIRTH** Jan (Month) 23 (Day) 1896 (Year)

7. **AGE** 24 Yrs. 5 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Real Estate
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Missouri

10. **NAME OF FATHER** George M. Brown

11. **BIRTHPLACE OF FATHER** (State or Country) Arkansas.

12. **MAIDEN NAME OF MOTHER** Elsie Fenton

13. **BIRTHPLACE OF MOTHER** (State or Country) Iowa.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) George M. Brown
(Address) Rupert R. F. D. no 1.

15. Filed Aug. 5 1920 E. W. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July (Month) 13 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The **CAUSE OF DEATH*** was as follows:

Killed By Train accident?

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Goodman M. D.

..... 19..... (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Boise Idaho | **DATE OF BURIAL** July 1 1920

20. **UNDERTAKER** W. A. Goodman | **ADDRESS** Rupert Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31245

Registered No.

1. PLACE OF DEATH.
County of Nez Perce
City of Culdesac
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 128
Primary Registration District No.
(No. Culdesac & Vicinity, St.)

2. FULL NAME Orrell Bonna Bartlett

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 27 (Day) 1901 (Year)

7. AGE: 18 yrs. 11 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Student
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Omar Bartlett

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Myrtle Spence

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clancy Bartlett
(Address) Culdesac Idaho

15. Filed July 1920 George Gaumnitz Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 9 - 1920, to July 9 - 1920 that I last saw h-r alive on July 9 1920, and that death occurred on the date stated above, at 11:00 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 1½ ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Gaumnitz M. D.
July 10 1920 (Address) Culdesac Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida. DATE OF BURIAL: July 10 1920

20. UNDERTAKER: C. J. Vassar ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16872

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
(No.....St.)

File No. 31246
Registered No.....

1. PLACE OF DEATH
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME May Winks
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 26 (Day) 1916 (Year)

7. AGE: 1 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE: Paul Ida (State or Country)

10. NAME OF FATHER: Albert G Winks

11. BIRTHPLACE OF FATHER: Utah (State or Country)

12. MAIDEN NAME OF MOTHER: Sylvia Criddle

13. BIRTHPLACE OF MOTHER: Utah (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert G Winks
(Address).....

15. Filed 8/14/20 19..... W W Stutsman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jul (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1920, to July 31 1920, that I last saw h— alive on —— 19....., and that death occurred on the date stated above, at.....M.

The CAUSE OF DEATH* was as follows:

Drowning (Accidental)

.....(Duration) Yrs. mos. ds.

Contributory (Secondary) Asphyxiation.

.....(Duration) Yrs. mos. ds.

(Signed) W W Stutsman M. D.

8/13 19 20. (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida
DATE OF BURIAL: Aug 1 1920

20. UNDERTAKER: J A Hodgson
ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 21247

Registered No.

Registration District No.

Primary Registration District No.

(No. [illegible] St.)

1. PLACE OF DEATH

County of Washington

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Jane Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widdow (Write the word.)

6. DATE OF BIRTH: Feb 29 1866 (Month) (Day) (Year)

7. AGE: 64 Yrs. 4 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE: ILL (State or Country)

10. NAME OF FATHER: M ###### M Walker

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER: Rhebeca Gwinn

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Anna L. Blake

(Address) Lore Oregon

15. Filed 8/14/26 19.....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7/11/ 19 20, to 7/15/ 19 20 that I last saw h.. alive on 7/15/ 19 20 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Peritonitis, following Obstruction of The Bowels

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E A Wiseman M. D.

7/16 1920 (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge

DATE OF BURIAL: July 14 1920

20. UNDERTAKER: J Abbedelson

ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31248
Registered No.

1. PLACE OF DEATH
County of Nez Perce
City of
(No. Sherman St.)
Registration District No.
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis Heinzerling
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 15 (Day) 1 (Year)

7. AGE: 64 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Paul Heinzerling

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. H. H. Heinzerling
(Address) Lewiston

15. Filed July 1920 George Gorman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19— to — 19—, that I last saw h— alive on — 19—, and that death occurred on the date stated above, at 8:40 P.M.
The CAUSE OF DEATH* was as follows:
Valvular heart trouble & Disease of Kidneys
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) O. H. H. Heinzerling
(Duration) — yrs. — mos. — ds.
(Signed) George Gorman M.D.
July 21 1920. (Address) Culdesac Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. — days. In the State — yrs. — mos. — days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston | DATE OF BURIAL: — 19—

20. UNDERTAKER: Larson | ADDRESS: Lewiston

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

BYNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31249
Registered No. 417

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gade D. Mounce

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	Sgl.

6. DATE OF BIRTH: July (Month) 16 (Day) 10 (Year)

7. AGE: 9 Yrs. 10 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: scholar
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston

10. NAME OF FATHER: L. Mounce

11. BIRTHPLACE OF FATHER (State or Country): Iowa,

12. MAIDEN NAME OF MOTHER: Anna Hayes

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. C. Mounce
(Address) Lewiston

15. Filed Aug 7th 1920 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 10 1920, to June 5th 1920 that I last saw h. alive on June 5th 1920 and that death occurred on the date stated above, at 2.15 P.M.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Duration) Yrs. mos. 26 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) O. C. Lawson M. D.
19 (Address) Lewiston Idy

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 6-7-1920

20. UNDERTAKER: J. Lawson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31250
Registered No. 416

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston
(No. St. Joseph's Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herbert A. Milliken

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word.)

6. DATE OF BIRTH May (Month) 28 (Day) 1896 (Year)

7. AGE 29 Yrs. 10 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wash

10. NAME OF FATHER L. D. Milliken

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Luella White

13. BIRTHPLACE OF MOTHER (State or Country) Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Clarkston Wn

15. Filed Aug 7 1920 Erwin E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23, 1920, to June 7 1920
that I last saw h[illegible] alive on June 5 1920
and that death occurred on the date stated above, at 1 10 M.
The CAUSE OF DEATH* was as follows:
Typhoid.
(Duration) Yrs. mos. 22 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Paul W Johnson M. D.
June 8 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 15 days. In the State yrs. mos. 15 days
Where was disease contracted if not at place of death? was working on surveying Crew on Tahsmania Ida
Former or usual residence Spokane Wash

19. PLACE OF BURIAL OR REMOVAL Spokane — DATE OF BURIAL June 1920

20. UNDERTAKER Cossar — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 3131
Registered No. 419

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. Main and 24th St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Kittsmiller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Aug (Month) 14 (Day) 1843 (Year)

7. AGE: 76 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: James Cardan

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Margaret Cardan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Kittsmiller
(Address)

15.
Filed Aug 7 1920
Bruce E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6th 1920, to June 9th 1920
that I last saw her alive on June 9th 1920
and that death occurred on the date stated above, at 11:15 A.M.
The CAUSE OF DEATH* was as follows:

Heart failure
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Bronchitis
(Duration) years yrs. ..... mos. ..... ds.
(Signed) L. J. Perkins M. D.
6/11 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 6/12 1920

20. UNDERTAKER: Sasse — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31252
Registered No. 420

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston, Ida. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Herman Meyers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August (Month) 30 (Day) 1899 (Year)

7. AGE: 20 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iron Mountain, Mich

10. NAME OF FATHER: Robert Meyers

11. BIRTHPLACE OF FATHER (State or Country): Two Rivers, Wis

12. MAIDEN NAME OF MOTHER: Ricka ~~EK~~ Godhe

13. BIRTHPLACE OF MOTHER (State or Country): Pichfield, Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Meyers
(Address) Clarkston, Wash.

15. Filed Aug 7 1920 — Susan E. Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 8th 1920 to June 10th 1920 that I last saw him alive on June 10th 1920, and that death occurred on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:

Shock

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Sarcoma Pancreas
(Duration) ..... yrs. 2 mos. ..... ds.
(Signed) D. C. Carador M. D.
19 ..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Clarkston, Wash.

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash — DATE OF BURIAL: 8/13 1920

20. UNDERTAKER: A R Merchant — ADDRESS: Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. ..... , ... St.)

File No. 31253
Registered No. 421

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph William Coffey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept 25th 1875 (Month) (Day) (Year)

7. AGE: 44 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Switchman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Galesburg Ill

10. NAME OF FATHER: Jeremiah Coffey

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Anna Flynn

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Coffey
(Address) 828-8/10th Ave. So. Lewiston

15. Filed Aug 7 1920
Alvan E. Bush (Clerk)
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 — 17 — 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6 — 17 — 1920 to June 1920, that I last saw him ~~alive~~ dead on 6 — 17 — 1920, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage
(Death occured in a few Mins.)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McDuahan M. D.
6-17 1920. (Address) 1726-7th Ave. Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	6-22-1920

20. UNDERTAKER	ADDRESS
C. J. Vassar	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31254
Registered No. 422

1. PLACE OF DEATH
County of Nezperce
City of Lewiston Ida.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles H Nicola
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~ (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 ..... (Year)

7. AGE: 51 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Nicola

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy C Pauley
(Address) Lewiston Ida

15. Filed Aug 7 1920 Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1920, to June 18 1920
that I last saw h.. alive on June 18 1920
and that death occurred on the date stated above, at 2:45 P.M.
The CAUSE OF DEATH* was as follows:
Hypernephroma of R Kidney
Post Operative shock

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Edgar L White M. D.
..... 19..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. In the State ..... yrs. ..... mos. 5 days
Where was disease contracted if not at place of death? .....
Former or usual residence Asotin Wash.

19. PLACE OF BURIAL OR REMOVAL: Asotin Wash — DATE OF BURIAL: 6/22 1920

20. UNDERTAKER: H P Merchant — ADDRESS: Clarkston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. ..... St.)

File No. 31255
Registered No. 423

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Ferguson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: March 10th 1866
(Month) (Day) (Year)

7. AGE: 55 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hack man
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Freedom, LaSalle County, Illinois

10. NAME OF FATHER: Chas A. Ferguson

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Eliza

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Chas. Ferguson
(Address): Missoula Mont

15. Filed Aug 7 – 1920 Noam E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 6 – 18 – 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6-13-1920, to 6-18-1920; that I last saw him alive on 6-18-1920; and that death occurred on the date stated above, at 1-20 P.M.

The CAUSE OF DEATH* was as follows:
Fibr Pneumonia

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. McMahan M. D.
6-19 1920. (Address) Lewiston, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston, Ida.	6/20 1920
20. UNDERTAKER: H.R.Merchant	ADDRESS: Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

(No. East Lewiston St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31256

Registered No. 4211

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carroll G Cudrus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W.	Single

6. DATE OF BIRTH March (Month) 12 (Day) 1901 (Year)

7. AGE 19 Yrs. 3 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ore.

10. NAME OF FATHER C G Cudrus

11. BIRTHPLACE OF FATHER (State or Country) Ore.

12. MAIDEN NAME OF MOTHER Mary Pearson

13. BIRTHPLACE OF MOTHER (State or Country) Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C G Cudrus

(Address) Lewiston

15. Filed Aug 7 1920 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1920 to June 26 1920 that I last saw h— alive on June 25 1920 and that death occurred on the date stated above at 1:50 A.M.

The CAUSE OF DEATH* was as follows:

Abdominal hernia

(Duration) Yrs. ..... mos. 3 ds.

Contributory (Secondary) adhesions from appendicitis operation

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John N. Kelly M. D.

19..... (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Lewiston Cemetery — DATE OF BURIAL 6/27 1920

20. UNDERTAKER Olson & Olson — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31257
Registered No. 425

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston,
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isaac James Simmons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 7th (Day) 1861 (Year)

7. AGE: 58 Yrs. 11 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmers
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Weldons Point Clark Co., Wash.

10. NAME OF FATHER: Alfred H. Simmons

11. BIRTHPLACE OF FATHER (State or Country): Monroe Co., N.Y.

12. MAIDEN NAME OF MOTHER: Sarah Irby

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret Case
(Address) Clarkston, Wash

15. Filed Aug 7 1920 Emma E Brun
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 30th 1920, to July 1st 1920 that I last saw him alive on July 1st 1920 and that death occurred on the date stated above, at 2 A.M.
The CAUSE OF DEATH* was as follows:
Emphysema
(Duration) ..... Yrs. 1 mos. 20 ds.
Contributory (Secondary) Pleurisy
(Duration) ..... yrs. 1 mos. 20 ds.
(Signed) John N Alley M. D.
19 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death X yrs. X mos. 1 days. In the State X yrs. X mos. 1 days
Where was disease contracted if not at place of death?
Former or usual residence Clarkston Wash

19. PLACE OF BURIAL OR REMOVAL: Clarkston, Wash
DATE OF BURIAL: 7/3/ 1920

20. UNDERTAKER: H.R.Merchant
ADDRESS: Clarkston, Wn.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31258
Registered No. 426

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clayton Dickson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: 27 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lapwai

10. NAME OF FATHER: Joe Dickson

11. BIRTHPLACE OF FATHER (State or Country): Lapwai

12. MAIDEN NAME OF MOTHER: Emma Dickson

13. BIRTHPLACE OF MOTHER (State or Country): Lapwai

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James G. Dickson
(Address) Sticks Ida

15.
Filed 19 Susan E Burns
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 25 1920, to July 1 1920
that I last saw h[illegible] alive on June 30 1920
and that death occurred on the date stated above, at 2. A.M.
The CAUSE OF DEATH* was as follows:

Typhoid Fever
Intestinal Hemorrhage
(Duration) Yrs. mos. ds.
Contributory (Secondary) Pneumonia Hypo
(Duration) 6 days yrs. mos. ds.

(Signed) J. Olin Wilbur M. D.
19 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lapwai — DATE OF BURIAL: 7/2 1920

20. UNDERTAKER: [illegible] Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31259
Registered No. 427

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 404 Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred B Bartlett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov 24 1845 (Month) (Day) (Year)

7. AGE: 54 6 8; Yrs. 74 Mos. 2 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Daniel L Bartlett

11. BIRTHPLACE OF FATHER (State or Country): N. H.

12. MAIDEN NAME OF MOTHER: Hannah Ann Ford

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. A. Bartlett
(Address) Ord Nebraska.

15. Filed Aug 7 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2 1920, to July 2 1920, that I last saw h... alive on July 2 1920 and that death occurred on the date stated above, at 4-30 P.M.
The CAUSE OF DEATH* was as follows:
Cancer

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Diabetes
(Duration) ... yrs. ... mos. ... ds.
(Signed) John Wall M. D.
19... (Address) ...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: ... 19...

20. UNDERTAKER: J Vassar — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1 1009
File No. 31260
Registered No. 428

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 1319 8th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia A. Stewart Ragon
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Married

6. DATE OF BIRTH: 2 (Month) 17 (Day) 1886 (Year)

7. AGE: 34 Yrs. 4 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) 9

9. BIRTHPLACE (State or Country) Calf.

10. NAME OF FATHER C. Heinzerling

11. BIRTHPLACE OF FATHER (State or Country) Ger.

12. MAIDEN NAME OF MOTHER Virginia Kent

13. BIRTHPLACE OF MOTHER (State or Country) Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C.W. Heinzerling
(Address) Lewiston Ida.

15. Filed Aug 7 1920 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 19, to July 2nd 1920, that I last saw her alive on July 2nd 1920, and that death occurred on the date stated above, at 6 15 M.

The CAUSE OF DEATH* was as follows:

Toxemia
(Duration) 1 Yrs. 7 mos. ..... ds.
Contributory (Secondary) Chronic nephritis
(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) C. E. Carson M. D.
19 ..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	7/4 1920

20. UNDERTAKER	ADDRESS
J. Hosea	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31261

Registered No. 429

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

Registration District No. 96

Primary Registration District No. 1009

(No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Corney

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 65 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [illegible]

(Address) [illegible] Board Co.

15. Filed Aug 7 19[illegible]

Susan E Bue
Registrar

[illegible] Registrar

Board Co

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to July 6 1920

that I last saw h[illegible] alive on July 6 1920

and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John N Alley M. D.

19[illegible] (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston

DATE OF BURIAL: 7/7 19[illegible]

20. UNDERTAKER: [illegible] Hosse

ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31262
Registered No. 430

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oblifton Cole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Feb (Month) 25th (Day) 1855 (Year)

7. AGE: 35 Yrs. 4 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer): Employed in Range Riding

9. BIRTHPLACE (State or Country): Atchison Co, Kno

10. NAME OF FATHER: William Arthur Cole

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Anna Scott Wallace

13. BIRTHPLACE OF MOTHER (State or Country): Lanpton Co Ont, Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W A Cole
(Address) 1617-9th Ave Lewiston, Idaho

15. Filed Aug 7 1920 Swan E Bowe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 7 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1920, to July 4 1920 that I last saw h-- alive on July 22 1920 and that death occurred on the date stated above, at 2.4 M.

The CAUSE OF DEATH* was as follows:
Tuberculosis
Pulmonis
Complicated with Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John B. Alley M. D.
19 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL 19 .....

20. UNDERTAKER: Lansar — ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31263
Registered No. 431

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. White's Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Jr. Garvin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Single

6. DATE OF BIRTH: Sept 5 (Month) (Day) 1897 (Year)

7. AGE: 23 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labourer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa,

10. NAME OF FATHER: J. W. Garvin

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Ida Beekly

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Garvin
(Address) 0114 18th St.

15. Filed Jul 7 1920 Sam E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased f[illegible] June 28 1920, to July 9 1920, that I last saw h[illegible] alive on July 9 1920 and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Syphilitic Meningitis

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) same
(Duration) ... yrs. ... mos. ... ds.
(Signed) E. L. White M. D.
19 ... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Negus Cem Ida	19
20. UNDERTAKER	ADDRESS
J Hasson	Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96

File No. 31264

Registered No. 432

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

Primary Registration District No. 1009

(No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John A Westling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

6. DATE OF BIRTH: May (Month) 17 (Day) 1882 (Year)

7. AGE: 38 Yrs. 2 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Da

10. NAME OF FATHER: Adolph Westling

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Not-Known

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J.M. Fowler

(Address)

15. Filed Aug 7 1920 Susan E Brace Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8th 1920 to July 15th 1920 that I last saw h[im] alive on July 15th 1920 and that death occurred on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) nephritis

(Duration) 1 yrs. mos. ds.

(Signed) A. C. Carson M. D.

19 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 7/17 1920

20. UNDERTAKER: Casson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31265
Registered No. 433

1. PLACE OF DEATH.
County of Nez Perce
City of Lewiston
(No. 306 5th Ave St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Jean Howe

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. July (Month) 3 (Day) 1920 (Year)
7. AGE: ....Yrs. ....Mos. 12 ds.
IF LESS than 1 day how many ....hrs. or ....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work....
(b) General nature of industry, business, or establishment in which employed (or employer)....
9. BIRTHPLACE (State or Country): Lewiston Ida.
10. NAME OF FATHER: Earl Howe
11. BIRTHPLACE OF FATHER (State or Country): Kansas.
12. MAIDEN NAME OF MOTHER: Anna Mitchell
13. BIRTHPLACE OF MOTHER (State or Country): Idaho
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo Mitchell
(Address) Lewiston Ida.
15. Filed Aug 7 1920 — Brian E Brown, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 15 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 26 1920, to July 15 1920, that I last saw h— alive on July 14 1920 and that death occured on the date stated above, at 3 A M.
The CAUSE OF DEATH* was as follows:

Premature Birth
7 mos Gestation

(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
(Duration ....yrs. ....mos. ....ds.
(Signed) C G Broadock M. D.
July 1920 (Address) Lewiston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?....
Former or usual residence ....

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 7/15 1920
20. UNDERTAKER: Geo Mitchell — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. ..... , ... St.)

File No. 31266
Registered No. 434

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine Kincaid.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Married

6. DATE OF BIRTH: July (Month) 31 (Day) 1 (Year)

7. AGE: 60 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lane Co. Ore

10. NAME OF FATHER Davis

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Do

13. BIRTHPLACE OF MOTHER (State or Country) Do

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jack Keenen
(Address) Nez Perce Idg

15. Filed Aug 7 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 26 1920 that I last saw h[illegible] alive on July 26 1920, and that death occurred on the date stated above, at 6:00 M.

The CAUSE OF DEATH* was as follows:
General Peritonitis
Ruptured Appendix

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Appendicitis
(Duration) ..... yrs. 2 mos. 21 ds.

(Signed) Geo. H. White M. D.
July 29 1920 (Address) Lewiston Idg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Walla Walla Wash	July 1920
20. UNDERTAKER E. J. Vassar	ADDRESS Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31267
Registered No. 435

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Holden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept (Month) 29 (Day) 1892 (Year)

7. AGE: 27 Yrs. 9 Mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Moscow, Idaho

10. NAME OF FATHER: Joseph Holden

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lurania Holden

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs George Holden
(Address): Wawawai, Wash.

15. Filed Aug 7 1920 — Ruth E. Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan, 1920 to July 26 1920 that I last saw him alive on July 26 1920 and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 year Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul W. Lamar M. D.

July 30 1920 (Address) Clarkston Wn.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. 2 days
Where was disease contracted if not at place of death? Do not know
Former or usual residence Clarkston Wash

19. PLACE OF BURIAL OR REMOVAL: Clarkston, Wash. DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: H.R. Merchant ADDRESS: Clarkston Wn.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31268
Registered No. 436

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 1 St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred E Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 24 (Day) 1919 (Year)

7. AGE: 1 Yrs. 2 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: L M Johnson

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Flora Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P M Johnson
(Address) Asotin Co Ida

15. Filed Aug 7 1920 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1920, to July 29 1920
that I last saw her alive on July 28 1920,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tubercular meningitis,

(Duration) 6 weeks Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul W Johnson M. D.
July 29 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Ida	7-30-1920

20. UNDERTAKER	ADDRESS
C J Vasson	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

File No. 31269

County of Oneida

City of Malad (No. ....., ... St.)

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph L Barnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married (Write the word.)

6. DATE OF BIRTH: June (Month) 3 (Day) 1898 (Year)

7. AGE: 22 yrs. 0 mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer.

9. BIRTHPLACE (State or Country) Layton Utah

10. NAME OF FATHER Ephraim Barnett.

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizebeth Perkins

13. BIRTHPLACE OF MOTHER (State or Country) Salt Lake City

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ephraim Barnett
(Address) .....

15. Filed July 30 1920 R M Maver M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1920, to July 1 1920
that I last saw h[illegible] alive on July 1 1920
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Chronic interstitial nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R T M[illegible] M. D.

July 1 1920 (Address) M[illegible] Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho | DATE OF BURIAL: July 3 1920

20. UNDERTAKER: J Guy Benson | ADDRESS

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 31270
Registered No. 28

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Thomas Fallis
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Married

6. DATE OF BIRTH
June (Month) 24 (Day) 1874 (Year)

7. AGE
46 Yrs. ..... Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Day Laborer
(b) General nature of industry, business or establishment in which employed (or employer) Employed as a butcher

9. BIRTHPLACE (State or Country) Malad Idaho

10. NAME OF FATHER John A. T. Fallis

11. BIRTHPLACE OF FATHER (State or Country) St. Louis Missouri

12. MAIDEN NAME OF MOTHER Catharine Thomas

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Sophie F. Williams
(Address) Malad Idaho

15. Filed July 30 1920
R. M. Manes M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Gun Shot, Self inflicted.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) James T. Blevens Corner M. D.
19..... (Address) Malad Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Malad Ida — DATE OF BURIAL 7-11 1920

20. UNDERTAKER W. E. Johnson — ADDRESS Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Owyhee
City of Nuland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ..... St.)

File No. 31271
Registered No. 29
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clarence R Bailey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Apr (Month) 22 (Day) 1919 (Year)

7. AGE: 1 yrs. 2 mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) School

9. BIRTHPLACE (State or Country) Emmett Idaho

10. NAME OF FATHER Willard Bailey

11. BIRTHPLACE OF FATHER (State or Country) Hillsville Pa.

12. MAIDEN NAME OF MOTHER Ann McCodrick

13. BIRTHPLACE OF MOTHER (State or Country) Canada Ont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Willard Bailey
(Address) .....

15. Filed July 30 1920 R T Mower Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 13 1920 to July 16 1920 that I last saw h[illegible] alive on July 16 1920 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
— Dysentery —

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. T. Mower M. D.
19 .... (Address) Mala, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jamaica	July 18 1920

20. UNDERTAKER	ADDRESS
J. Guy Benson	Mala Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 43

Primary Registration District No. 2120

File No. 31272

County of Owyhee

City of Silver (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe Chanez

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male (wife of .....)

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH — Unknown (Month) 1 (Day) (Year)

7. AGE "about," 35 yrs. ... mos. ... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep-herder and
(b) General nature of industry business, or dstablishment in which employed (or employer): camps - herders

9. BIRTHPLACE (State or Country): Spain, Castile.

10. NAME OF FATHER: Unknown (F. Chanez?)

11. BIRTHPLACE OF FATHER (State or Country): Spain (Cordova)

12. MAIDEN NAME OF MOTHER: Unknown (Mrs. F. Chanez?)

13. BIRTHPLACE OF MOTHER (State or Country): Spain (Cordova)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. Th. Stacy
(Address) Silver City, Idaho

15. Filed July 3 1920. W. H. Schuyler, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h— alive on ..... 191...,
and that death occurred on the date stated above, at 7.10 A.M.

The CAUSE OF DEATH* was as follows: Coroner's Inquest.
Gunshot Wound right chest, shot (25/35) entering at angle right scapula 3rd coming out just below right clavicle, 2" from sternum, puncturing arch of aorta.
(Duration) ... yrs. ... mos. ... ds.

~~Contributory~~ Death due to hemorrhage from
(~~Secondary~~) puncture of aorta by bullet.
(Duration) ... yrs. ... mos. ... ds.

(Signed) W. H. Schuyler M. D.
July 3, 1920 (Address) Murphy, Idaho
County Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Silver City, Idaho — DATE OF BURIAL: July 4, 1920

20. UNDERTAKER: John Grete — ADDRESS: Silver City, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 7009
File No. 31273
Registered No. 8

1. PLACE OF DEATH.
County of Payette
City of New Plymouth (No. R 707, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Sherman Brown
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W.	

6. DATE OF BIRTH: July (Month) 24 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many 8 hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho -

10. NAME OF FATHER Wm Harrison Brown

11. BIRTHPLACE OF FATHER (State or Country) Ill -

12. MAIDEN NAME OF MOTHER Emma Josephine Schroeder

13. BIRTHPLACE OF MOTHER (State or Country) Ill -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Wm H. Brown -
(Address) New Plymouth Ida

15. Filed July 25 1920 Wm J. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 24 1920, to July 24 1920, that I last saw him alive on " " 1920, and that death occurred on the date stated above, at 11.57 P.M.

The CAUSE OF DEATH* was as follows:
Lack of foetal development.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory Premature birth
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J. Drysdale M. D.
7-25 1920 (Address) New Plymouth

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
New Plymouth	7-25 1920

20. UNDERTAKER	ADDRESS
L. P. Detrick	New Plymouth Ida

(Friend)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

WHITE CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 2072
File No. 3127
Registered No. 1021

1. PLACE OF DEATH
County of Power
City of Am Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benard B Muehlen

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Sep (Month) 17 (Day) 1886 (Year)

7. AGE 33 Yrs. 10 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Council Bluffs Iowa

10. NAME OF FATHER: Charles Benard Muehlen

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Ida Gluesthman

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs B B Muehlen
(Address) Am Falls. Ida

15. Filed 8-9 1920 R. L. Nott Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h.....alive on ..... 191...,
and that death occured on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Drowned.

.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
.....(Duration .....yrs. .....mos. .....ds.
(Signed) Chas Davis Coroner
8-9 1920 (Address) Am Falls. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Am Falls Pioneer Cem — DATE OF BURIAL: July 23 1920
20. UNDERTAKER: Chas Davis — ADDRESS: Am Falls Idaho

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 123

Primary Registration District No. 9701

(No. ....., ... St.)

1. PLACE OF DEATH

County of Shoshone

City of Gardner

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Burton Charles Brickell

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31275
Registered No. 33275
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. (Month) Dec (Day) 15 (Year) 1865

7. AGE: 54 Yrs. 7 Mos. 2 ds.

IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Thomas J. Brickell

11. BIRTHPLACE OF FATHER (State or Country): Cincinnati Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Bickell

13. BIRTHPLACE OF MOTHER (State or Country): Richmond Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gladys B. Brickell
(Address) Gardner Idaho

15. Filed 7/24 1920 Geo. D Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) July (Day) 17 (Year) 1920

17. I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 17 1920 that I last saw him alive on July 17 1920 and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Fibroid Phthisis

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

7/24/20 (Signed) Geo. D. Lesher M. D.
7/24 1920 (Address) Kellogg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: July 20 1920

20. UNDERTAKER: M. C. Thornhill — ADDRESS: Kellogg Idaho

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 12216
Registered No. .....

Registration District No. 123
Primary Registration District No. 7101
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Vergobbi

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. ..... (Month) 9 (Day) 1894 (Year)

7. AGE: 26 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Vergobbi

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Miss Comonni

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Vergobbi
(Address) .....

15. Filed 7/18 19.. Geo. S. Lasher
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning
.....
.....
.....(Duration) ..... Yrs..... mos. ....., ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) Geo. S. Lasher M. D.
7/18 19.. (Address) Coroner

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: June 13 1920

20. UNDERTAKER: M. C. Thomkins — ADDRESS: Kellogg Ida

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31277
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2201
(No. North Fork Coeur d'Alene River St.)

2. FULL NAME Henry Leonard Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. February (Month) 5th (Day) 1909 (Year)

7. AGE: 11 Yrs. 4 Mos. 1 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph Anderson

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Ida Erickson

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Anderson
(Address) Wallace, Idaho.

15. Filed 7/18 1920. Geo S Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 6th (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at ....,....M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) Geo S Lesher M. D.
.....19.... (Address) Coroner

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: July 1 1920

20. UNDERTAKER: M C Chambers — ADDRESS: Wallace

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 24 31278
Registered No.

1. PLACE OF DEATH
County of Teton
City of Driggs
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richart Roehling
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 6 (Day) 1893 (Year)

7. AGE: 27 Yrs. 10 Mos. 25 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Fred Roehling

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Berta Hiese

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Leo Bothermel
(Address) Gooding, Idaho.

15.
Filed Aug 7th 1920 Martha Marker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1920 to July 31 1920
that I last saw h. alive on July 31 1920
and that death occurred on the date stated above, at 7:15 P.M.
The CAUSE OF DEATH* was as follows:
Fracture of base of skull

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Chas J Martin M. D.
July 31 1920 (Address) Driggs, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Leigh, Nebraska. DATE OF BURIAL 19

20. UNDERTAKER: Chas
ADDRESS Driggs, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of -

(No. ..... St.)

Registration District No. 36

Primary Registration District No. .....

File No. 31279

Registered No. 15

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Olsen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

6. DATE OF BIRTH: Jan 18 (Month) (Day) 1 (Year)

7. AGE: 55 Yrs. 6 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Peter Olsen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Mary Mathelson

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl R. Olsen
(Address) Hansen Idaho

15. Filed July 24 1920 J N Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 12 1920 to July 23 1920 that I last saw him alive on July 21 1920 and that death occurred on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows:

Cancerous Ulcer

(Duration) 4/12 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Fractured Femur

(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) J N Davis M. D.

7/24 1920 (Address) Hansen Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 7-25-1920

20. UNDERTAKER: [illegible] — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of " " — Primary Registration District No. 1085

(No. ..... St.)

File No. 31280

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles D. Uhlendorf

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct. (Month) 12 (Day) 1875 (Year)

7. AGE: 44 Yrs. 9 Mos. 11 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mercantile

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Charles Uhlendorf

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Rebecca Tiddeke

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Cora M. Uhlendorf

(Address) 816 E. Marquette Rd.

15. Filed July 27 1920 — John F. Coughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19, 1920, to July 23 1920, that I last saw him alive on July 23 1920, and that death occurred on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Streptococcus Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary): .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Duncan F. Uhlendorf M.D.

7/24 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill. — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: P. J. Graham — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31281
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085

2. FULL NAME Nellie Stinnett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 12 1890 (Month) (Day) (Year)

7. AGE: 30 Yrs. 3 Mos. 26 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Allen Blevins

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Nellie Ward

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey Stinnett
(Address) Hagerman Idaho

15. Filed Aug 3 1920 John H Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 1 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1920, to Aug 1st 1920, that I last saw h.r alive on Aug 8 1920 and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) Yrs. 1 8 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) [signature] M. D.
Aug 7 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wellens Cely DATE OF BURIAL 19

20. UNDERTAKER: J E Leavitt ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31282
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Lyle Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write one word.)
Male	white	Married

6. DATE OF BIRTH: July (Month) 9 (Day) 1880 (Year)

7. AGE: 60 Yrs. Mos. 22 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Joseph Green

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Elizabeth Green

13. BIRTHPLACE OF MOTHER (State or Country): Ga.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter. Green
(Address)

15. Filed Aug 3 1920 John Y Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ post mortem to 19..., that I last saw him ~~alive~~ on Aug. 1, 1920, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from lateral sinus & compound skull fracture received in auto accident
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E. R. Van Cott, M. D.
8-1- 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Aug 4 1920

20. UNDERTAKER: J E Venrick — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 10857
File No. 31283
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carlton Brainard
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

6. DATE OF BIRTH: Dec 10 (Month) 1877 (Day) (Year)

7. AGE: 43 Yrs. 7 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer): Farmer & Stock Raiser

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Bradley Brainard

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Allie Lord

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J E Elwell
(Address):

15. Filed Aug 3 1920 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1920, to Aug. 2 1920; that I last saw h[illegible] alive on Aug. 2 1920. and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Acute Stenosis
Mitral Regurgitation
(Duration) 10 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. F. Passer M. D.
19 (Address) Boyd Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: Aug 4 1920

20. UNDERTAKER: J E Elwell | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31284
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorathy Parish

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov 19 (Month) (Day) 1 (Year)

7. AGE: 7 Yrs. 8 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W S Parish

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Nora McCarter

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.S. Parish
(Address) Twin Falls Ida

15. Filed July 21 1920 John F Coughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1920, to July 19 1920 that I last saw her alive on July 19 1920 and that death occurred on the date stated above, at 9:10 A.M.

The CAUSE OF DEATH* was as follows:

Scalded

(Duration) ..... Yrs. ..... mos. 12 hr

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Boyd M. D.
7-20-1920 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: 7-21 1920

20. UNDERTAKER: F E Hewett | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31285

Registered No. .....

1. PLACE OF DEATH

County of Twin Falls

City of .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Owen W Owen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: March 17 1902
(Month) (Day) (Year)

7. AGE: 18 Yrs. 8 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wash

10. NAME OF FATHER: Morris Owen

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Micki E Roberts

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Morris Owen
(Address) R.D.#1 Twin Falls

15. Filed July 24 1920 John Houghlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 23 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1920, to July 23 1920, that I last saw him alive on July 23 1920, and that death occurred on the date stated above, at 9.10 P.M.

The CAUSE OF DEATH* was as follows:

Compound basal skull fracture from auto-horse accident.

(Duration) 0 Yrs. 0 mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E.R. Van Cott, M. D.

7-24 1920. (Address) Twin Falls, Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Cem. | DATE OF BURIAL: 7-25 1920

20. UNDERTAKER: J E Wentz | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1045

File No. 31286
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Soria
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 13 (Day) 1920 (Year)

7. AGE: Yrs. Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho ~~Mexico~~

10. NAME OF FATHER: Canonino Soria

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Isabel Bofob

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ignacio Soria
(Address)

15. Filed Aug 1 1920 John Y Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1920 to July 25 1920
that I last saw h[illegible] alive on July 24 1920
and that death occurred on the date stated above, at 11 30 AM.
The CAUSE OF DEATH* was as follows: Broncho Pneumonia

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) T S Mason M. D.
7-26 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida | DATE OF BURIAL: 7-26 1920

20. UNDERTAKER: J E Ward | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

Primary Registration District No. 1085

File No. 31287

City of ( ) (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write word): Single

6. DATE OF BIRTH: 7 (Month) 24 (Day) 20 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Jones

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Hilda [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John D Jones

(Address) .....

15. Filed July 26 1920 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-20 1920 to 7-25 1920 that I last saw h... alive on 7-25 1920 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T Strachan M. D.

7/26 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: 7-26 1920

20. UNDERTAKER: L E Veatch ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No. 1085
File No. 51288
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of "
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)

2. FULL NAME Chas. E. Kitching

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May 18 (Month) (Day) 1883 (Year)

7. AGE: 37 Yrs. 2 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Wm H Kitching

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Julia Caldwell

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Essie E. Kitching
(Address) Kimberly, Idaho

15. Filed July 27 1920 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1920 to July 21 1920 that I last saw h— alive on July 21 1920 and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Accidental- Fracture of Skull
(Duration) — Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J M Davis M. D.
7/22 1920 (Address) Kimberly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 7/24 1920
20. UNDERTAKER: P. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31289
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of —
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A Brady Awly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Saxon
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Nov 16 (Month) 16 (Day) 1850 (Year)

7. AGE: 40 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Andrew Awly

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Mahala McClain

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Dr J E Awly
(Address): Boise Ida

15. Filed July 31 1920 John F Coughlin Local Registrar

1920
7-31
80

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-21 1920 to 7-31 1920 that I last saw h[illegible] alive on 7-30 1920 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. S. Hanson M. D.

7/31 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Audubon, Mo

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 7-31 1920

20. UNDERTAKER: J E Wyatt — ADDRESS: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1055
File No. 31290
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma - Ashton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write One word.): Married

6. DATE OF BIRTH: April 1 (Month) (Day) [redacted] (Year)

7. AGE: Yrs. 15 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: R L Ashton

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Nellie Woodhead

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Ashton
(Address)

15. Filed July 14 1920. John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5th 1920, to July 11 1920, that I last saw her alive on July 11 1920, and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) Whooping Cough
(Duration) yrs. mos. 15 ds.

(Signed) Chas R. Scott M. D.
7-14 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho
DATE OF BURIAL: 7-14 1920

20. UNDERTAKER: J E Hewett
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1045
File No. 31291
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John B. Kerr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mah
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Write the word

6. DATE OF BIRTH: Dec. (Month) 29 (Day) 1855 (Year)

7. AGE: 64 Yrs. 6 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Miss.

10. NAME OF FATHER: James Kerr

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J P Kerr
(Address) 144 1st west.

15. Filed July 16 1920 John Y Coughlan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 4:35 A.M.
The CAUSE OF DEATH* was as follows:
Heart Failure
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J P Groesman M.D.
7/14 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 7/16 1920
20. UNDERTAKER: J P Groesman
ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of Twin Falls (No. ..... St.) — Primary Registration District No. 1685 —

File No. 31202

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna May Carlson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 28 (Day) 1888 (Year)

7. AGE: 31 Yrs. ..... Mos. 14 ds. ..... IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Welch

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not Kno.

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur A Carlson
(Address) Filer Idaho

15. Filed July 16 1920 John F Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 7 (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7th 1920, to July 14th 1920, that I last saw her alive on July 14 1920, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Streptococcus
Septicaemia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F. Coughlin M. D.
7/16 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 7-18 1920

20. UNDERTAKER: E E Verett — ADDRESS: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31293
Registered No.

1. PLACE OF DEATH
County [redacted] Falls
City (No. , St.)
If outside limits of city or town, write the name of township.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frannie Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: May (Month) 5 (Day) 1851 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mississippi

10. NAME OF FATHER: Samuel Martin

11. BIRTHPLACE OF FATHER (State or Country): N. Car.

12. MAIDEN NAME OF MOTHER: Maggie Moore

13. BIRTHPLACE OF MOTHER (State or Country): N. Car.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. C. Trumpeed.
(Address)

15. Filed Aug 4 1920 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/ /1920, to 8/3/1920
that I last saw h[illegible] alive on 8/3/1920
and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of bladder infection
(Duration) 0 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
8/3 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nichols Farm, Tf. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. C. Devitt ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 31294
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Kimberly
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nathan R. Barnhill
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: March (Month) 20 (Day) 1850 (Year)

7. AGE: 70 Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Robert Barnhill

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Mary Ann Compton

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary A. Barnhill
(Address) Kimberly

15. Filed July 16 1920 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan — 1920, to July 10 1920
that I last saw h— alive on July 10 1920
and that death occurred on the date stated above, at 10 a.m.
The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1/2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. W. Welch M. D.
July 10 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 7/12 1920.

20. UNDERTAKER: J. J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 8085
File No. 31295
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Josephine I Rusk
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 13 1 (Month) (Day) (Year)

7. AGE: 98 Yrs. 3 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ark

10. NAME OF FATHER: Hall Leggett

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Margret -

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter A Rusk
(Address) Hansen Ida

15. Filed July 14 1920 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1920 to July 13 1920
that I last saw her alive on July 13 1920
and that death occurred on the date stated above, at 4:45 A.M.
The CAUSE OF DEATH* was as follows:
Acute dilatation of Heart
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J F Boyd M. D.
July 14 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: July 14 1920
20. UNDERTAKER: L E Elwell | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31297

Registered No.

1. PLACE OF DEATH

Registration District No. 34

County of Twin Falls

Primary Registration District No. 2071

City of Buhl (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Patterson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH: May (Month) 21st (Day) 1844 (Year)

7. AGE: 86 yrs. 1 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: John Patterson

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Hughes.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Patterson Jr.
(Address) Buhl. Idaho

15.
Filed 7-17 1920 J. R. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 15 1920 that I last saw him alive on July 15 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(Chronic)

(Duration) Do not know. yrs. ..... mos. ..... ds.

Contributory (Secondary): Senility.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Irmen, M. D.

July 16 1920 (Address) Buhl Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl, Ida.

DATE OF BURIAL: July 19th 1920

20. UNDERTAKER: H. B. Evans

ADDRESS: Buhl, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2084
File No. 31298
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Effie Susan Busch
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: Feb. (Month) 25 (Day) 1883 (Year)

7. AGE: 36 Yrs. 4 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Jacob Coffman

11. BIRTHPLACE OF FATHER (State or Country): Not Known.

12. MAIDEN NAME OF MOTHER: Atty. Formley.

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. M. Busch.
(Address) .....

15. Filed July 22 1920 J. V. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1920 to July 16 1920 that I last saw h.er alive on July 16 1920 and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 4 Yrs. — mos. — ds.
Contributory (Secondary) Asthenia
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) F. A. Irmen. M. D.
July 22 1920 (Address) Buhl Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: July 22 1920

20. UNDERTAKER: Stewart & Pugh — ADDRESS: Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31299
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Midvale
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 87
Primary Registration District No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pauline Betbenner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Oct. (Month) 30 (Day) 1919 (Year)

7. AGE: ..... Yrs. 5 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Not Employed
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Harry Betbenner

11. BIRTHPLACE OF FATHER (State or Country) Nebraska

12. MAIDEN NAME OF MOTHER Pauline Hengler

13. BIRTHPLACE OF MOTHER (State or Country) Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry Betbenner
(Address) Midvale Ida

15. Filed 4-1-1920 F. A. Schmidt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: April (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 3-31-1920, to April 1-1920, that I last saw her alive on Mar. 22-1920, and that death occured on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Failure of Tarcomen rule
2 days. Heart stopped
(Blue Baby) Atelectasis
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Schmidt M. D.
4-1-1920 (Address) Midvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Ontario oregon
DATE OF BURIAL: ..... 191...

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No.
(No. , St.)

File No. 31300
Registered No.

1. PLACE OF DEATH
County of Washington
City of ~~Gambl Idaho~~ Meridale
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Colson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widdower (Write the word.)

6. DATE OF BIRTH: Oct 22 1834 (Month) (Day) (Year)

7. AGE: 85 Yrs. 9 Mos. 29 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Jm. Colson
(Address) Cambridge Ida.

15. Filed 7-22-1920 Fuelchmitz Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July 21 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1920 to July 18 1920 that I last saw h[illegible] alive on July 18 1920 and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:
apoplexy

(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) Senility
(Duration) yrs. mos. ds.
(Signed) Fuelchmitz M. D.
July 1920 (Address) Meridale Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Columbus — DATE OF BURIAL: July 22 1920

20. UNDERTAKER: J A Fiedelem — ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 87

Primary Registration District No.

File No. 31301

County of Washington

City of Midvale

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Effie M. Whiteside

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 26 (Day) 1872 (Year)

7. AGE: 47 Yrs. 9 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Grand Mason Co

10. NAME OF FATHER: M G Rader

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Ga

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roy Steel

(Address) Emmett Ida

15.

Filed 7-27- 1920

Tatchmix

Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h... alive on ..... 191...,

and that death occured on the date stated above, at about 1 20 P.M.

The CAUSE OF DEATH* was as follows:

Heart Disease. Had not attended deceased before and did not see her until after death

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) W. T. Bielby M. D.

19... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Midvale Valley Cem — DATE OF BURIAL: 6-23-1920

20. UNDERTAKER: F R Robinson — ADDRESS: Midvale Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No.
(No. , St.)

File No. 31303
Registered No.

1. PLACE OF DEATH.
County of Washington
City of Midvale
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. Grace Cumbell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. (Month) Aug. (Day) 7 (Year) 1867
7. AGE: 52 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Tenn
10. NAME OF FATHER: Joseph Campbell
11. BIRTHPLACE OF FATHER (State or Country): Tokepa Pierce
12. MAIDEN NAME OF MOTHER: Beckey Pierce
13. BIRTHPLACE OF MOTHER (State or Country): Tenn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jerry Miner
(Address) Midvale Idaho.
15. Filed 6-14-1920 191 F. A. Schmidt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to June 12 1920, that I last saw h.. alive on June 11 1920, and that death occured on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows: Spotted fever Mottey
(Duration) Yrs. mos. 12 ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) F. A. Schmidt M. D.
6-12 1920 (Address) Midvale Idah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Midvale — DATE OF BURIAL: 6-12 1920
20. UNDERTAKER: L. R. Parkinson — ADDRESS: Midvale Ida

SYMS - YORK CO., PTRS. & STNRS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31304
Registered No. .....

Registration District No. 87
Primary Registration District No. .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Washington
City of Midvale

2. FULL NAME William Ehrich

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Feb (Month) 17 (Day) 1838 (Year)

7. AGE: 87 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Henry Ehrich.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. August Jens
(Address) Midvale

15.
Filed 6-18 1920
Fabchmitz
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
6 (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 12:30 M.

The CAUSE OF DEATH* was as follows:
Found Dead in bed

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Senility
(Duration 3 yrs. 0 mos. ..... ds.

(Signed) Fabchmitz, M. D.
6-19 1920 (Address) Midvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Midvale Cemetery	6-16 1920
20. UNDERTAKER	ADDRESS
C R Parkinson	Midvale

FORM V. S. No. 5-28 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31305
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Nyndale
If death occurs away from usual residence, give facts called for under special information.

Registration District No 87
Primary Registration District No .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emily Towell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Oct. (Month) 20 (Day) 1844 (Year)

7. AGE
78 Yrs. 7 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... House Wife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Ill

10. NAME OF FATHER
Fletcher

11. BIRTHPLACE OF FATHER
(State or Country) England

12. MAIDEN NAME OF MOTHER
Burns

13. BIRTHPLACE OF MOTHER
(State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Effie J Keithley
(Address) Midvale Idaho

15.
Filed ..... 191....
Fa Schmaltz
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
June (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1920, to June 18 1920, that I last saw her alive on June 18 1920, and that death occured on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Paralysis & Senility

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Fa Schmaltz M. D.
6-19 1920 (Address) Midvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Keithley Creek — DATE OF BURIAL: June 19 1920

20. UNDERTAKER: G R B Sanitarium — ADDRESS: Midvale Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 91306
Registered No.

Registration District No.
Primary Registration District No.

1. PLACE OF DEATH
County of Boise
City of McCall (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paul Ranta
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Ml.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 7 (Day) 1909 (Year)

7. AGE: 11 Yrs. 1 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Finnland

10. NAME OF FATHER: Arnael Ranta

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Julia Lundman

13. BIRTHPLACE OF MOTHER (State or Country): Dont know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mother & Uncle
(Address) Rock Springs Wyoming

15.
Filed 10/8 1920 W. P. Murphy
~~Local~~ Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-5 1920, to 8-14 1920
that I last saw him alive on 8-14 1920,
and that death occurred on the date stated above, at 7 PM.
The CAUSE OF DEATH* was as follows:
Typhoid fever

(Duration) Yrs. mos. 14 ds.
Contributory (Secondary) General debility
(Duration) yrs. mos. ds.

(Signed) H. C. Robinson M. D.
10-2-1920 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31307
Registered No. 285

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1204
(No. St. Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Matt E. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: Colored.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: June 28 (Month) (Day) 1871 (Year)

7. AGE: 49 Yrs. 1 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chef.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mattie Smith
(Address) Salt Lake City, Utah

15. Filed 8-11 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1920 to Aug 10 1920 that I last saw him alive on Aug 10 1920 and that death occurred on the date stated above at ..... M.
The CAUSE OF DEATH* was as follows:
Fatty Heart
Cardiac Embolism.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Fractured Femur Operation Reduction
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Almond M. D.
8/11 1920 (Address) Courland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City, Utah | DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: Summers & Keeler | ADDRESS Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM 1 S. No. 6-25 M 2-19

CERTIFICATE OF DEATH

21308

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada
Registration District No. 12
Primary Registration District No. 2
File No. 21308

City of Boise (No. Soldiers Home, St.)
Registered No. 89

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Nitcher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan 18 (Month) (Day) 1835 (Year)

7. AGE: 85 Yrs. 7 Mos. 28 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: John Nitcher.

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Quackenbush

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. T. Nitcher
(Address) Weiser

15. Filed 9/18 1920 R. H. Coate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep 16 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to Sep 16 1920
that I last saw h[illegible] alive on Sept 15 1920
and that death occurred on the date stated above, at 5.0 P.M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ...Yrs...mos...ds.

Contributory (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) Fred A. Tuthill M. D.
9/17 1920 (Address) Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death...yrs...mos...days. In the State...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sep 18 1920

20. UNDERTAKER: Summers & Cobb. — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1004
File No. 31309
Registered No. 337

1. PLACE OF DEATH
County of Ada
City of Boise,
(No. 914 W. S. Ave. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Catherine J Kelly.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White.	Single

6. DATE OF BIRTH Oct — 1840
(Month) (Day) (Year)

7. AGE 80 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Ireland.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anne E. Risley
(Address) .....

15. Filed Oct 7 — 1920 R. H. Beebe
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 7 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 22 1920, to Oct. 6 1920, that I last saw h— alive on Oct. 6 1920, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:
Chronic myocarditis.

(Duration) 10 Yrs. mos. ds.
Contributory (Secondary) Senility,
(Duration) yrs. mos. ds.

(Signed) J. Earl Hill. M. D.
10/7/19 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hartford Conn	19
20. UNDERTAKER	ADDRESS
Summers & Cobbs	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 3131
Registered No. 294

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 710 112 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Patrick A Conner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) ... (Day) 1867 (Year)

7. AGE: 53 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Section Foreman
(b) General nature of industry, business or establishment in which employed (or employer): U.S.L. at Caldwell

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Wm P. Conner

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizth Bolger

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John A Conner
(Address) Baker, Ore.

15. Filed Aug 26 1920 — P. H. Postle, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1920, to Aug 22 1920, that I last saw h.m alive on Aug 22 1920, and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Liver ?
... (Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) ...
... (Duration) ... yrs. ... mos. ... ds.
(Signed) H. E. Smith M. D.
8/23 1920 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence Caldwell

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery | DATE OF BURIAL ... 19...

20. UNDERTAKER: Schneider & Eden Sons | ADDRESS 8/27/20 Boise

Dr. Smith

FORM V. S. No. 5-'5 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5171

Registration District No.
Primary Registration District No.
Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410 W. State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Howard Ernest Halverson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Aug (Month) 23 (Day) 1903 (Year)

7. AGE: 17 Yrs. 0 Mos. 8 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Dakota.

10. NAME OF FATHER: H. M. Halverson

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Amalia Schneider

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. M. Halverson.
(Address) Boise Idaho.

15. Filed Sept 1 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Aug 31 1920, to 19..... and that I last saw him alive on Aug 31 1920, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Fracture of skull
Fell from moving Auto truck
(Duration) ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner
9/ 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 3 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31312
Registered No. 293

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. 1607 - N. 16th St.)

2. FULL NAME Thomas J. Mathers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Married

6. DATE OF BIRTH: April (Month) 23 (Day) 1854 (Year)

7. AGE: 66 Yrs. 4 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Thomas J. Mathers

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Nancy Burkey

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos. E. Mathers
(Address) 1607 - N. 16th St.

15. Filed Sept 1 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/5 1920 to 8/31 1920
that I last saw him alive on 8/31 1920
and that death occurred on the date stated above, at 4P M.
The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Carcinoma Stomach
(Duration) ... yrs. ... mos. ... ds.

(Signed) F. H. Hughes M. D.
9/1 1920 (Address) Owsley Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	9/2 1920

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31513
Registered No.

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. 410 State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sam Hing

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Yellow
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 1838 (Day) (Year)

7. AGE: 82 Yrs. — Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant at
(b) General nature of industry, business or establishment in which employed (or employer): Idaho City

9. BIRTHPLACE (State or Country): Canton, China

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S. Hing
(Address) Boise Ida

15. Filed Sept 4 1920 R. H. Coats Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3d 1920, to Sept 3 1920, that I last saw h alive on Sept 3 1920, and that death occurred on the date stated above, at 6 A M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
(Duration) Yrs. mos. ds.
Contributory (Secondary) Pneumonia
(Duration) yrs. 6 mos. ds.
(Signed) J H Goodfellow M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho 10 yrs.

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery
DATE OF BURIAL: 9/6 1920
20. UNDERTAKER: Schreiber & Siebenfaden
ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Brother

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31314

Registered No. 239

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 411 Washington St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Harvey Ross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 4 (Day) 1920 (Year)

7. AGE: Yrs. Mos. 31 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rupert Ida

10. NAME OF FATHER: Jerry Ross

11. BIRTHPLACE OF FATHER (State or Country): Ray Co. Mo.

12. MAIDEN NAME OF MOTHER: Sulla Ethel Brown

13. BIRTHPLACE OF MOTHER (State or Country): Loveland Col.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jerry Ross Boise

(Address)

15. Filed Sept 7 1920 R. H. Pride Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug Sept 1 1920 to Sept 4 1920 that I last saw h. alive on Sept 3 1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Acute Entro Colitis

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W S Titus M. D.

9-7 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 9/6 1920

20. UNDERTAKER: Fisher & Sidenberg | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr Titus

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31315
Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 1010 East Jefferson St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME. Everett Ralph Walker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Single

6. DATE OF BIRTH: June (Month) 20 (Day) 1916 (Year)

7. AGE: 4 Yrs. 2 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: Austin A. Walker

11. BIRTHPLACE OF FATHER (State or Country): Minnesota

12. MAIDEN NAME OF MOTHER: Lydia Grigsby

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. G. Walker

(Address) Boise Idaho,

15. Filed 9/7 - 1920 M. H. Coats Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 5 1920, to Sept. 6 1920, that I last saw h.. alive on Sept. 6 1920, and that death occurred on the date stated above, at 3 9 M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Earl Weir M. D.

9/6/20 19..... (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/7 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____

Primary Registration District No. 1194

File No. 31316

Registered No. 307

1. **PLACE OF DEATH**

County of Ada

City of Boise

(No. St. Alphonsus Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Mrs. Jennie L. Riner

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** F.

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Married (Write the word.)

6. **DATE OF BIRTH** Aug. 29 1865
(Month) (Day) (Year)

7. **AGE** 55 Yrs. 0 Mos. 6 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business or establishment in which employed (or employer) ____

9. **BIRTHPLACE** (State or Country) New York State.

10. **NAME OF FATHER** Barnes

11. **BIRTHPLACE OF FATHER** (State or Country) New York.

12. **MAIDEN NAME OF MOTHER** Don't Know.

13. **BIRTHPLACE OF MOTHER** (State or Country) " "

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Wm McBratney

(Address) Boise Idaho.

15. Filed 9-7- 1920 R. H. Coats
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Sept. 5 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1920 to Sept 5 1920 that I last saw her alive on Sept 4 1920 and that death occurred on the date stated above, at 29 M.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) Uraemia

(Duration) ____ yrs. ____ mos. 5 ds.

(Signed) WS Lutes M. D.

9-6 1920. (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	9-6 1920.
20. UNDERTAKER W. McBratney	**ADDRESS** Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3131
Registered No. 302

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410, Steele St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hudson J. Hubbard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 2 (Month) 2 (Day) 1869 (Year)

7. AGE: 51 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Johnson Co. Mo

10. NAME OF FATHER: Silas Hubbard

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Mitchell

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Hubbard

(Address) Meadows

15. Filed 9-7-1920 R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1920 to Sept 6 1920, that I last saw h... alive on Sept 6 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Congestion Apoplexy
Coronary Thrombosis

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Chronic Cystitis

(Duration) ... yrs. ... mos. ... ds.

(Signed) James L Stewart M. D.

9/7 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence Meadows Ida

19. PLACE OF BURIAL OR REMOVAL: Meadows Ida. DATE OF BURIAL: 9/9 1920

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31318

Registered No. 303

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 1116 Franklin St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 2004

2. FULL NAME Ralph A Goodliffe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: July (Month) 5th (Day) 1848 (Year)

7. AGE: 72 Yrs. 1 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Eng

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. H. Dawson

(Address) Boise Ida.

15. Filed 9-7 1920

R. H. Coote
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1920, to Sept 4 1920 that I last saw h.im alive on Sept 3 1920, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Smith M. D.

9/7 1920 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery | DATE OF BURIAL: 9/6 1920

20. UNDERTAKER: Schmuck & Sidmore | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31319
Registered No. 204

1. PLACE OF DEATH

Registration District No.

Primary Registration District No. 1004

County of Ada

City of Boise (No. 715 N. 8 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin Ellsworth Bradley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Jan. (Month) 12 (Day) 1898 (Year)

7. AGE: 22 Yrs. 7 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Traveling Salesman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Del

10. NAME OF FATHER: Geo B. Bradley

11. BIRTHPLACE OF FATHER (State or Country): Del

12. MAIDEN NAME OF MOTHER: Katie E. Hanson

13. BIRTHPLACE OF MOTHER (State or Country): Del

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo B Bradley
(Address) 715 N. 8 St

15. Filed Sept 10 1920 R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Sept 8 1920 to ~~1920~~, that ~~I last saw h~~ alive on ~~1920~~, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers M. D.
9/9 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Sept 11 1920
20. UNDERTAKER	ADDRESS
Summers & Krebs	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. ____

Primary Registration District No. 1004

(No. 612 Hays St.)

File No. 31321

Registered No. ____

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Jacob Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: December (Month) 2 (Day) 1848 (Year)

7. AGE: 71 Yrs. 9 Mos. 7 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Paperer and Painter

(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Mercer, Ill

10. NAME OF FATHER: Albert Jacob Taylor

11. BIRTHPLACE OF FATHER (State or Country): Lancaster Penn.

12. MAIDEN NAME OF MOTHER: Jeannette Marsh

13. BIRTHPLACE OF MOTHER (State or Country): Delaware

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs W. G. Smenden.

(Address) 612 Hays St.

15. Filed 9/10 1920

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1920 to Sept. 9 1920 that I last saw him alive on Sept. 8 1920 and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 3 Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. W. Kingsbury M. D.

Sept 1920 (Address) 404 Idaho Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ogden Utah	9/10 1920

20. UNDERTAKER: Schreiber & Anderson ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31322

Registered No.

1. PLACE OF DEATH

County of Ada.

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 1116 W. Jefferson St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maria H Morgan.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: March 10 (Month) (Day) 1835 (Year)

7. AGE: 85 Yrs. 5 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Elliott Harroun

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Lucinda Hastings

13. BIRTHPLACE OF MOTHER (State or Country): Mass

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Geo. M. Brown
(Address): 1116 Jefferson st

15. Filed Sept 11 1920 — R. L. Coale, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ Sept 9 1920 to ..... 19..... that I last saw her alive on dead Sept 9 1920, and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E Summers Coroner
9/9 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 12 1920

20. UNDERTAKER: Summers & [illegible] — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31925
Registered No. 709

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. 1812 N. 19 St.)

2. FULL NAME Susan J. Hiester

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 29 (Day) 1851 (Year)

7. AGE: 68 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: William Alexander

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Hiester
(Address) Boise Ida

15. Filed 9/11 1920 R. H. Pratt Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1920 to Sept 8, 1920
that I last saw her alive on Sept 7th 1920
and that death occurred on the date stated above, at 6-30 A. M.

The CAUSE OF DEATH* was as follows:

Pyaemia

(Duration) Yrs. 1 mos. 8 ds.

Contributory (Secondary) Glycosuria

(Duration) Yrs. unknown mos. ds.

(Signed) R. S. Gregory M. D.
Sept. 10 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 10 1920

20. UNDERTAKER: Summers & Tabb — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Ida.
BOARD OF HLTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 107 E Grove St.)

File No. 31324

Registered No. 310

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ahijah Stanison Costo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Dec 4 1841 (Month) (Day) (Year)

7. AGE: 79 Yrs. 7 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Jacob Costo

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Mat Oblannard

13. BIRTHPLACE OF MOTHER (State or Country): Wales England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H D Costo

(Address) Boise Idaho

15. Filed 9/12 1920

R. H. Coats
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Sept 10 1920

that I last saw h[illegible] alive on Sept 10 1920

and that death occurred on the date stated above, at 3 3[illegible] M

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H M Halverson M. D.

19..... (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: 9/12 1920

20. UNDERTAKER: Schreiber & Hildenbrand ADDRESS: Boise

Halverson.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31325

Registered No. 312

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No.) 2504 West Jefferson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henriette Beel

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Feb. (Month) 2 (Day) 1857 (Year)

7. AGE: 63 Yrs. 7 Mos. 9 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: William Fisher

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Warfield

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Alice S Bell

(Address) 2504 Jefferson St.

15. Filed 9/13 1920

R. H. Price
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 19..., to Sept 11 1920 that I last saw her alive on Aug 25 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Multiple Spinal Sclerosis

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary) Cardiac Paralysis

(Duration) yrs. mos. 1 ds.

(Signed) T. H. Braxton M. D.

Sept 11 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days. In the State ...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Sept 13 1920

20. UNDERTAKER: Summers & Cobb

ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise (No. 410, State St.)

Registration District No. 2

Primary Registration District No. 4

File No. 31326

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gertrude A. Passmore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 21st (Day) 1893 (Year)

7. AGE: 26 Yrs. 10 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: Thos J Lynch

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Louisa Mines

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A Schreiber

(Address) Boise

15. Filed 9/13 1920 R. H. Coate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 12th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1920, to Sept 12 1920, that I last saw her alive on Sept 11 1920, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Tubercular peritonitis

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Tuberculosis Salpingitis

(Duration) yrs. 3 mos. ds.

(Signed) Jos. R. Kennedy M. D.

8/13 1920. (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 9/14 1920

20. UNDERTAKER: Terteling & Sidenfaden — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31328

Registered No. 314

1. PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 110 East Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kenneth C. Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept 10th 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: C. S. Moore

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Alice Ethel Brassfield

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C S Moore

(Address) Boise

15. Filed 9/20 1920

P. S. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 14th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1920 to Sept 14 1920 that I last saw him alive on Sept 14 1920 and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M Allen Dunaway M. D.

1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/14 1920

20. UNDERTAKER: Schreiber & Nicholson — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 15 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 1004
File No. 31329
Registered No. 315

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 110 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Merrill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Unknown (Month) (Day) 1848 (Year)

7. AGE: 75 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Simmons
(Address) Boise Ida.

15. Filed Sept 14 1920

P. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1920, to Sept 12 1920
that I last saw him alive on Sept 12 1920
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Senile Degeneration

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) P. P. French M. D.
Sept 14 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: Sept 15 1920

20. UNDERTAKER: Simmons & Kirk | ADDRESS: Boise Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31330

Registered No. 316

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1094

(No. 110 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emma M. Shawver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married

6. DATE OF BIRTH: May (Month) 4 (Day) 1876 (Year)

7. AGE: 44 Yrs. 4 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John P. Linstrum

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Caroline Malm

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. Linstrum

(Address) Boise Idaho R F D 4

15. Filed Sept 14 1920 R H Coats Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 14 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1920, to Sept 14 1920, that I last saw h.er alive on Sept 14 1920, and that death occurred on the date stated above, at 4a M.

The CAUSE OF DEATH* was as follows:

Surgical Shock

(Duration) 12hrs

Contributory (Secondary) Caesarean Section (Duration)

(Signed) C H Walker M. D.

9/14 1920 (Address) 303 McCarty Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 15 1920

20. UNDERTAKER: Summers & Kirby — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31331

Registered No. 318

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 141 Warm Springs Ave. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Nettie Bicknell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 16 (Day) 1863 (Year)

7. AGE: 57 Yrs. 1 Mos. 29 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario Canada

10. NAME OF FATHER: Lewis Stover

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Charlotte Lane

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McBratney

(Address) Boise. Idaho.

15. Filed 9/16 1920 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1920 to Sept 15 1920 that I last saw her alive on Sept 12 1920 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of abdominal organs.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Cancer of ovary.

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) J. A. Springer M. D.

9-16 1920 (Address) Boise. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kingston, Ontario Canada

DATE OF BURIAL 19

20. UNDERTAKER: W. McBratney

ADDRESS: Boise. Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31332
Registered No. 319

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 410, State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Patrick Hayes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: About 1871
(Month) (Day) (Year)

7. AGE: About 49 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: actor

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Dublin Ireland

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sr. Jane Chantal Idaho

(Address) St. Alphonsus Hospital Boise

15. Filed 9/18 1920

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 17 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16 1920 to Sept 17 1920 that I last saw him alive on Sept 16 1920, and that death occurred on the date stated above, at 2:00 P.M.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis of lungs.

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Roscoe C. Ward M. D.

9-17 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	9/20 1920

20. UNDERTAKER	ADDRESS
Pioneer Redemptorist	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31333

Registered No. 325

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise (No. 110 E Bannock St)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma J. Scott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: W

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Nov. 23, 1872 (Month) (Day) (Year)

7. AGE: 47 Yrs. 9 Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: I. D. Livingood

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Nicol Scott
(Address) Boise Idaho

15. Filed 9/21 1920

R. H. Rath
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1920 to Sept 20 1920
that I last saw h.e alive on Sept 20 1920
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:

Burned to death

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lou Barker M. D.

Sept 21 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery DATE OF BURIAL: Sept 23 1920

20. UNDERTAKER: Summers & Turbs ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31334
Registered No. 321

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1523 W. Washington St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Susan A. Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan 20 (Month) (Day) 1867 (Year)

7. AGE: 53 Yrs. 8 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: David Winter

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Charlotte A. Neal

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo. H. Campbell

(Address) 1523 Washington St.

15. Filed 9/21 1920

R. H. Watt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 20 1920 to Sept 20 1920 that I last saw h[illegible] alive on Sept. 20 1920 and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Aorta.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. H. Clum M. D.

9-21 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept 22 1920

20. UNDERTAKER: Summers & Treb[illegible] — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31335

Registered No. 322

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 410 State St.)

2. FULL NAME Gracie Caroline Monroe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June 2 (Month) (Day) 1916 (Year)

7. AGE: 4 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: F. C. Monroe

11. BIRTHPLACE OF FATHER (State or Country): Boise

12. MAIDEN NAME OF MOTHER: Rosey Mutemahan

13. BIRTHPLACE OF MOTHER (State or Country): N. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. C. Monroe

(Address) 808 Eastman St.

15. Filed 9 21 1920

P. H. Pace
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-18 1920, to 9-21 1920, that I last saw her alive on 9-20 1920, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Enteric Colitis, acute.

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P. H. Eastman M. D.

9/21 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/21 1920

20. UNDERTAKER: Schreiber & Siddoway — ADDRESS: Boise

Heirs

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31336
Registered No. 923

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410 W. State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Sandstrom
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Married

6. DATE OF BIRTH: Feb. (Month) 1868 (Day) (Year)

7. AGE: 52 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Dahlberg

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Sandstrom
(Address) Arbon

15. Filed 9/21 1920 O. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 16 1920, to Sept 19 1920, that I last saw her alive on Sept 19 1920, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Obstruction of bowel (duodenum)

(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) Rupture of Gall Bladder
(a) peritonitis (Duration) yrs. mos. ds.

(Signed) L. A. McCalla M. D.
9/20 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade Idaho, DATE OF BURIAL: Sept 24 1920

20. UNDERTAKER: Summers & Tabor ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31337
Registered No. 324

1. PLACE OF DEATH
County of Ada
City of Boise (No. 623 So 13 / St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Pruett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (write the word.)

6. DATE OF BIRTH: Jan 21 (Month) (Day) 1913 (Year)

7. AGE: 7 Yrs. 8 Mos. 0 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Lee Pruett.

11. BIRTHPLACE OF FATHER (State or Country): Miss.

12. MAIDEN NAME OF MOTHER: Mary Jackrell

13. BIRTHPLACE OF MOTHER (State or Country): Arizona.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lee Pruett
(Address) 623 So 13 St

15. Filed 9/22 1920 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1920 to Sept 21 1920 that I last saw her alive on Sept 20 1920 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows: Membranous Croup

(Duration) Yrs. mos 5 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo. H. Handy M. D.
9/22 1920 (Address) 916 State St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

13. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? From sick child visiting home
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Sep 23 1920
20. UNDERTAKER	ADDRESS
Summers & Co.	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Pittsburgh

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31338
Registered No. 326

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1015, No 17 St.)

Registration District No. 2
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maud R. Griffin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
F	White	Married

6. DATE OF BIRTH
Nov 23 1865
(Month) (Day) (Year)

7. AGE
54 Yrs. 10 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE
(State or Country) Nebraska.

10. NAME OF FATHER Jesse Spielman

11. BIRTHPLACE OF FATHER
(State or Country) Penn

12. MAIDEN NAME OF MOTHER Sarah J. Keister

13. BIRTHPLACE OF MOTHER
(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S. Griffin
(Address) 1501 N 19th Boise

15. Filed Sept 27 1920 R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1920, to Sept 26 1920
that I last saw h er alive on Sep 26 1920
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:

Hemiplegia

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Valvular Heart Disease
(Duration) ... yrs. ... mos. ... ds.
(Signed) Fred A. Haughey M. D.
9/27 1920 (Address) Caxton Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Sept 28 1920.
20. UNDERTAKER Lemmon & Kobe.	ADDRESS Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31340

Registered No. 328

1. PLACE OF DEATH

County of Ada.

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 1903 W 9 st / St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martin V. Ingraham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	White	Married

6. DATE OF BIRTH Jan. (Month) 2. (Day) 1840 (Year)

7. AGE 80 Yrs. 8 Mos. 22 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Abraham Ingraham

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Hastbrauck

(Address) 1903 W. 9

15. Filed 9/28 1920 R. H. Prado Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1920, to Sept 25 1920, that I last saw h.. alive on Sept 25 1920 and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. D. Smith M. D.

9/27 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. ..... mos. ..... days. In the State..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Sept. 29 20

20. UNDERTAKER: Summers & Tate — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31341
Registered No. 329

1. PLACE OF DEATH
County of Ada
City of Boise (No. 400 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jake Beeler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: About 1853 (Month) (Day) 1 (Year)

7. AGE: about 67 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranger
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Schreiber
(Address) Boise

15. Filed 9/30 1920 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 27 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 20 1920 to Sept 27 1920 that I last saw h[illegible] alive on Sept 27 1920, and that death occurred on the date stated above, at 8.45 P.M.
The CAUSE OF DEATH* was as follows:
1 Tuberculosis Spine
1 Tuberculosis Lungs
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Ralph F. [illegible] M. D.
9/29 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	9/30 1920
20. UNDERTAKER	ADDRESS
Schreiber & Liedenfadin	Boise

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2064
File No. 31342
Registered No. 81

1. PLACE OF DEATH

County of Ada
City of Boise
(No. East Boise Res Potlatch St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Adeline Barron.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug 23 1920. (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 18 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise. Idaho.

10. NAME OF FATHER: W. C. Barron.

11. BIRTHPLACE OF FATHER (State or Country): Colo

12. MAIDEN NAME OF MOTHER: Carrie Ranta

13. BIRTHPLACE OF MOTHER (State or Country): Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise Idaho.

15. Filed 9/10 1920 P. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 9 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 1st 1920 to Sep 9th 1920 that I last saw h. alive on Sep 9th 1920, and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) 0

(Duration) ____ Yrs. ____ mos. ____ ds.

(Signed) Chas Baeck M. D.

9/10 1920. (Address) Boise. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9-10 1920

20. UNDERTAKER: W. McBratney — ADDRESS: Boise Idaho.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31343
Registered No. ....

Registration District No. 8
Primary Registration District No. 2004

1. PLACE OF DEATH
County of Ada
City of Barber
(No. ....., Barber St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Evelyn May Brooks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 15th (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. — ds.
IF LESS than 1 day how many .... hrs. or ..... min.? 5 hrs

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Barber, Idaho

10. NAME OF FATHER: Victor M. Brooks

11. BIRTHPLACE OF FATHER (State or Country): Delamar, Idaho

12. MAIDEN NAME OF MOTHER: Nellie Irene Cook

13. BIRTHPLACE OF MOTHER (State or Country): Great Falls, Montana, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBritney
(Address) Boise Idaho

15. Filed 9/17 1920
R. H. Pratt
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 15th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15th 1920 to ..... 191..
that I last saw her alive on ..... 191....
and that death occurred on the date stated above, at 11 ... P. M.

The CAUSE OF DEATH* was as follows:
Traumatism, from
abdominal rupture
at birth
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) R. S. Gregory M. D.
19.... (Address) Barber, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: 9/17 1920 191...

20. UNDERTAKER: W. McBritney
ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31344

Registered No. 83

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. Rose Hill St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME C. E. Stevens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 27 (Day) 1857 (Year)

7. AGE: 63 Yrs. 3 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mining Engineer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cincinnati Ohio

10. NAME OF FATHER: Charles Stevens

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mc Clintock

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Stevens

(Address) Boise

15. Filed 9/17 1920

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1920 to Sept 16 1920 that I last saw h[illegible] alive on Sept 8 1920, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows: Tuberculosis, acute miliary

(Duration) Yrs. 11 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Gallman M. D.

9/16 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 9/18 1920

20. UNDERTAKER: Schreiber & Sidenham — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Filed.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31345

Registered No. 271

1. PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 2

Primary Registration District No. 1004

(No. 1215 East Washington St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Teuscher

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH: July (Month) 8 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Joseph Teuscher.

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Neva L. Anderson.

13. BIRTHPLACE OF MOTHER (State or Country): W. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Teuscher
(Address) .....

15. Filed Aug 2 1920 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 7 A M.
The CAUSE OF DEATH* was as follows:
Don't know
Did not see deceased until
after death.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Earl Hill M. D.
8/2/20 19..... (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem.	Aug 2 1920.
20. UNDERTAKER	ADDRESS
Summers & Tebb.	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Ada

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31346

Registered No. 273

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise

(No. St. Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earnest W. Michael

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White.	Single

6. DATE OF BIRTH: July 26 1920
(Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 6 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Irvin A. Michael

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Esther A Liddiard

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Irvin A. Michael
(Address) Boise

15. Filed Aug 3 1920 L O Summers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 1 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1920, to Aug 1 1920
that I last saw him alive on Aug 1 1920
and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Congenital absent Anus - rectum & Colon

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Earl [illegible] M. D.

8/3 1920. (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. ..... mos. ..... days. In the State..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Aug 3 1920
20. UNDERTAKER	ADDRESS
Summers & Gebb	Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31347
Registered No. 274

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410 State St.)
Registration District No. 2
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Gill
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 5th 1905 (Month) (Day) (Year)

7. AGE: 14 Yrs. 8 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Garfield Wash.

10. NAME OF FATHER: J. E. Gill.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Alda Goheen

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Gill
(Address) Boise.

15. Filed Aug 7 — 1920 C. P. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 4th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1920 to Aug 4 1920 that I last saw h[illegible] alive on Aug 4 1920 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Accident, crushed
Thorax internal hemorrhage

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas V. Kenney M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: 8/6 1920

20. UNDERTAKER: Schrieber & Sidenfaden ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31348

Registered No. 276

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. 1004

(No. St Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Lynch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F.	White	Married (or Widowed.)

6. DATE OF BIRTH: Aug (Month) 16 (Day) 1 (Year)

7. AGE: 29 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Edward Kemp.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Jennie Sunton

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Lynch

(Address) J. J.

15. Filed Aug 6 1920 C. H. Ball Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1920 to Aug 5 1920 that I last saw h.r alive on Aug 5 1920 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P P French M. D.

Aug 6 1920 (Address) 417 Overland Bldg Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	19.....
20. UNDERTAKER: Summers & Gebs.	ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31349
Registered No. 277

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 112 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank E. Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

6. DATE OF BIRTH: Mar (Month) 16 (Day) 1893 (Year)

7. AGE: 27 Yrs. 4 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockbuyer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ada Co. Idaho.

10. NAME OF FATHER: John Patterson

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Lucy Peck

13. BIRTHPLACE OF MOTHER (State or Country): Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred S. Patterson
(Address)

15. Filed Aug 9 1920 — R. H. Crall, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1920, to Aug 7th 1920, that I last saw h... alive on Aug 7th 1920, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:
Acute Gastro-enteritis-

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Peritonitis, from chronic [illegible] Liver disease -
(Duration) Unkn yrs. ..... mos. ..... ds.

(Signed) R. M. Taylor M. D.
Aug 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 4 days. In the State of Idaho ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Boise, Idaho St.
Former or usual residence Boise, Idaho St.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Aug 10 1920
20. UNDERTAKER: Schreiber & Sidenfaden	ADDRESS: Boise

Dr. Taylor

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31350
Registered No. 278

Registration District No.
Primary Registration District No. 1104

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 101 N. 27. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jerome Ellsworth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1869 (Year)

7. AGE: 51 Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Edmond Ellsworth

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Mary A Dudley

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marie Ellsworth
(Address) 101 N 27th St

15. Filed Aug 9 - 1920 R. A. Cook Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from Aug 7 1920 to 1920
that I last saw ~~him~~ alive on and Aug 7 1920
and that death occurred on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:
Carcinoma of face
Attending Physician out of state
(Duration) 2 Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Clyde E Summers M. D.
8/9 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE. (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cem. Ada. | DATE OF BURIAL: Aug 10 1920
20. UNDERTAKER: Summers & Kreft | ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31351

Registered No. 279

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 110 E Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Flora Anna Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Widow

6. DATE OF BIRTH: Oct 31 1886 (Month) (Day) (Year)

7. AGE: 33 Yrs. 9 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W H Otte

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Sarah Ballantyne

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Lady Thorpe
(Address): Boise Ida

15. Filed 8-9 1920 R. E. Osborne Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-31 1920 to 8-8- 1920
that I last saw her alive on 8-8- 1920
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Sarcoma -

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R J Cluen M. D.
8-9 1920 (Address) Boise - Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 10 1920

20. UNDERTAKER: Summers & Ford — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31352
Registered No. 281

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

2. FULL NAME Clyde Merritt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Mar 29 1903 (Month) (Day) (Year)

7. AGE: 17 Yrs. 4 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Forest Service
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Meadows Idaho

10. NAME OF FATHER: J. W. Merritt

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Lucy McReynolds

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W Merritt
(Address) New Meadows Ida

15. Filed 8-8 1920 R H Oates Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 7th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1920 to Aug 7 1920
that I last saw him alive on Aug 7 1920
and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Peritonitis from
Sarcoma of Bowels
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R P French M. D.
Aug 8 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Meadows Ida — DATE OF BURIAL: 8/8 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr. French 1407 Hays.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31353
Registered No. 282

1. PLACE OF DEATH

County of Ada
City of Boise
(No. St Alphonsus Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kenneth Thomas Andrews,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: May (Month) 26 (Day) 1912 (Year)

7. AGE: 8 Yrs. 2 Mos. ~~xxx~~ ds. 15

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Notus Idaho

10. NAME OF FATHER: O.T.Andrews

11. BIRTHPLACE OF FATHER (State or Country): Parma Idaho.

12. MAIDEN NAME OF MOTHER: Anna V. Spaeth

13. BIRTHPLACE OF MOTHER (State or Country): St. Louis Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. McBratney
(Address) Boise, Ida.

15. Filed 8 — 1 1920 R H Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1920 to Aug 9 1920 that I last saw him alive on Aug 9 1920, and that death occurred on the date stated above, at 11:30 PM

The CAUSE OF DEATH* was as follows:
Meningitis (streptococcic)

(Duration) — Yrs. — mos. 7 ds.
Contributory (Secondary) Mastoiditis
(Duration) — yrs. — mos. 10 ds.

(Signed) Ed E Mayer M. D.
8-9 1920 (Address) Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lower Boise Cemetery Near Notus, Idaho, — DATE OF BURIAL: 8-11 1920

20. UNDERTAKER: Wm McBratney — ADDRESS: Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 31354
Registered No. 283

1. PLACE OF DEATH
County of Ada
City of Boise
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Philip Charrier
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 15th 1917 (Month) (Day) (Year)

7. AGE: 3 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston, Idaho

10. NAME OF FATHER: Chas P. Charrier

11. BIRTHPLACE OF FATHER (State or Country): Calumet, Mich

12. MAIDEN NAME OF MOTHER: Florence Bell

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. P. Charrier
(Address) 1506 No 20th St.

15. Filed 8-12 1920 R. H. Coates Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~July~~ August 9th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/6 1920, to 8/8 1920
that I last saw h... alive on 8/8 1920,
and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:
Myenbranous Croup following Tonsilitis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Don Numbers M. D.
By C. P. Charrier
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Payette Lakes, Idaho
Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery | DATE OF BURIAL: 8/12 1920
20. UNDERTAKER: Schreiber & Siebyaden | ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31355

Registration District No. 2
Primary Registration District No. 1204
Registered No. 284

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.
(No. 110 E. Bannock (St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Hall Webber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the Word.): Single

6. DATE OF BIRTH: Jan (Month) 3 (Day) 1919 (Year)

7. AGE: 1 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: John F. Webber

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Margaret M. MacLean

13. BIRTHPLACE OF MOTHER (State or Country): N. D.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles MacLean
(Address) 1421 E. Jeff. Boise

15. Filed 8-12 1920 R H Pate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1st 1920, to August 11th 1920, that I last saw him alive on August 10th 1920, and that death occurred on the date stated above, at 5 AM.

The CAUSE OF DEATH* was as follows:
Gastro-enteritis acute

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. L. Frazier M. D.
8/11/20 (Address) 515 Overland Bldg, Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Aug 13 1920

20. UNDERTAKER: Dennis & Tribe
ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3135

Registered No. 286

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 315 N. 2. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Adelia Corbin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb. 26 1846 (Month) (Day) (Year)

7. AGE: 74 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Lewis D. Corbin

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Elizabeth Dickinson

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louise Corbin

(Address) B/S S 2nd

15. Filed 8-16 1920 R. H. Coats Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1920, to Aug 13 1920, that I last saw her alive on Aug 13 1920, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Rowe T Porter M. D.

Aug 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 16 20

20. UNDERTAKER: Summers & Stubs — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31357

Registered No. 287

1. PLACE OF DEATH

County of Ada

City of Baise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 412 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eusebio Iraola

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Single

6. DATE OF BIRTH: Aug 14 1920 (Month) (Day) (Year)

7. AGE: ....Yrs. ....Mos. 1 ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Baise, Ada

10. NAME OF FATHER: Marcos Iraola

11. BIRTHPLACE OF FATHER (State or Country): Spain

12. MAIDEN NAME OF MOTHER: Leona Maruri

13. BIRTHPLACE OF MOTHER (State or Country): Spain

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marcos Iraola
(Address) Baise

15. Filed Aug 18 1920 R H Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 15 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1920 to Aug 16 1920 that I last saw h.m. alive on Aug 16 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ....Yrs. ....mos. 1 ds.

Contributory (Secondary)
(Duration) ....yrs. ....mos. ....ds.

(Signed) O H Parker M. D.
19.... (Address) McCall Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	8/16 1920

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS (Boise)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1074
File No. 31556
Registered No. 288

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. A. Crouch
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: about 1855 (Month) (Day) (Year)

7. AGE: about 65 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canonsburg, Penn

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. J. Moritz
(Address) Boise Ida

15. Filed Aug 18 1920 R. H. Pratt Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/1 1917, to 8/1 1920
that I last saw h[illegible] alive on 8/1 1920
and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
General Paralysis
for 10 years.

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Jos. R. Mumbro M. D.
8/16 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) Hospital
At place of death 6 yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Midvale Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/17 1920
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31359

Registered No. 289

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

(No. 1115, W. Washington St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella E. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Single

6. DATE OF BIRTH: Aug (Month) 21st (Day) 1859 (Year)

7. AGE: 60 Yrs. 11 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: retired housekeeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montour Falls N.Y.

10. NAME OF FATHER: Wm Thos. Jones

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): American

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Hannah

(Address)

15. Filed Aug 17 1920

D H Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 16th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1919, to ..... 19....., that I last saw h.. alive on Aug 10 1920, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leo Callaway M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence: Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery | DATE OF BURIAL: 8/17 1920

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: (Boise)

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1014
File No. 31360
Registered No. 390

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410 State St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John L. Hammer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb 21st 1896 (Month) (Day) (Year)

7. AGE: 23 Yrs. 9 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: Wm F. Hammer

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Effie L. Peacock

13. BIRTHPLACE OF MOTHER (State or Country): Mont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm F Hammer
(Address)

15. Filed Aug 23 1920 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. Pittinger

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 21st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/14 1920, to 8/21 1920
that I last saw h[illegible] alive on 8/20 1920
and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:

Apnea

(Duration) Yrs. mos. ds.
Contributory (Secondary) Appendix Abscess
(Duration) yrs. mos. ds.

(Signed) F. A. Pittenger M. D.
8/21 1920 (Address) Capitol Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 8/23 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Shurtz.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31361

Registered No. 291

1. **PLACE OF DEATH**

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 307 N. 2 st St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sallie V. Blood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March 22 1849 (Month) (Day) (Year)

7. AGE: 71 Yrs. 4 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: John Baker

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Blessing

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) J. G. Blood Boise Ida

15. Filed Aug 22 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 3 1920 to Aug 21 1920 that I last saw h[illegible] alive on Aug 19 1920 and that death occurred on the date stated above, at 11 PM.

The CAUSE OF DEATH* was as follows:

Diabetes Comma

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Diabetes Sacchar

(Duration) yrs. mos. ds.

(Signed) R E Shurtz M. D.

Aug 21 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 22 1920

20. UNDERTAKER: Summers & Webb — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31362

Registered No. 73

1. **PLACE OF DEATH**

County of Ada.

City of Boise.

(No. 3 miles west of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Andrew C. Christian

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male.	White	Married

6. **DATE OF BIRTH** May 21 - 1870
(Month) (Day) (Year)

7. **AGE** 50 Yrs. 4 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Minister of
(b) General nature of industry, business or establishment in which employed (or employer): Advent Church

9. **BIRTHPLACE** (State or Country) Owatonna, Minn.

10. **NAME OF FATHER** Hans Christian

11. **BIRTHPLACE OF FATHER** (State or Country) Denmark.

12. **MAIDEN NAME OF MOTHER** Irena Hanson.

13. **BIRTHPLACE OF MOTHER** (State or Country) Denmark

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) W. McBratney
(Address) Boise, Idaho.

15. Filed Aug 2 1920 P. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** July 29 - 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1920, to July 29 1920, that I last saw him alive on July 28 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Epilepsia

(Duration) 15 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis

(Duration) ..... yrs. 1 mos. 4 ds.

(Signed) T. N. Braxton M. D.

7/29 1920. (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill	8/3 - 1920.

20. UNDERTAKER	ADDRESS
W. McBratney	Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31363

Registered No. 74

1. PLACE OF DEATH

County of Ada

City of Near Boise (No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph C Morris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: 1847 (Month) 1 (Day) (Year)

7. AGE: 83 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Veteran of Civil War

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Maryland

10. NAME OF FATHER: Nimrod Morris

11. BIRTHPLACE OF FATHER (State or Country): Maryland

12. MAIDEN NAME OF MOTHER: Elizabeth A Birely

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) 1711 24th Boise Idaho

(Address) A L Morris

15. Filed Aug 2 1920 R. H. Coats Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 1st 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1920 to Aug 1st 1920

that I last saw h... alive on July 31 1920

and that death occurred on the date stated above, at 6-15-0 M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Accidental Drowning by automobile

(Duration) ... yrs. ... mos. ... ds.

(Signed) Roscoe C Ward M. D.

8-2 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Aug 2 1920

20. UNDERTAKER: Summers & Krebs

ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31364

Registered No. 75

Registration District No. 8

Primary Registration District No. 2004

1. PLACE OF DEATH

County of Ada,

City of

If death occurs away from usual residence, give facts called for under special information.

(No.) 3 Miles N.W. of Boise.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christian M. Bontrager

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH

Oct. 8 1840
(Month) (Day) (Year)

7. AGE

79 Yrs. 9 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER C. M Bontrager

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Susan Miller

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Bontrager

(Address) Boise Idaho

15. Filed Aug 2 1920 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug 2 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1920, to Aug 2 1920, that I last saw h— alive on Aug 1 1920, and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... Yrs. ... mos. 5 ds.

Contributory (Secondary) Chronic Valvular Heart disease

(Duration) 3 yrs. ... mos. ... ds.

(Signed) R. E. Shurtz M. D.

Aug 2 1920 (Address) 323 Overland Bldg Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Aug 3 1920

20. UNDERTAKER: Summers & Kreps — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31365

Registered No. 76

1. PLACE OF DEATH

County of Ada

City of Mas Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2004

(No. Soldiers Home St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alexander M. Rowe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Dec 24 1842 (Month) (Day) (Year)

7. AGE: 77 Yrs. 6 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired School

(b) General nature of industry, business or establishment in which employed (or employer): Professor

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. O. Rowe

(Address) 7411 Eggleston Ave Chicago Ill.

15. Filed Aug 5 1920

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 2 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 21 1920 to Aug 2 1920

that I last saw h[illegible] alive on July 21 1920

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Senility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred C. Tetreault M. D.

8/5 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Aug 6 1920

20. UNDERTAKER: Summers & Trefz

ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31367

Registered No. 78

1. PLACE OF DEATH

County of Ada

City of

(No. Soldiers Home St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mat. Tridel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1874. (Year)

7. AGE: 76 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Veteran Civil War.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E. Summers

(Address) Boise Idaho

15. Filed Aug 28 1920 R. H. Coats Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1920 to 8/27 1920 that I last saw him alive on 8/27 1920 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Cancerous of Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Furey M. D.

8/28 1920 (Address) Cleveland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Aug 28 20

20. UNDERTAKER: Summers & Trebo

ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 8 or 4
File No. 31368
Registered No. 79

1. PLACE OF DEATH
County of Ada
City of Boise (or near)
(No. Idaho State Prison St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis St Clair
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Red Indian
5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word.): single

6. DATE OF BIRTH: ~~Aug~~ ~~28~~ ~~1896~~ (Month) (Day) (Year)

7. AGE: 24 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ft Peck Mont

10. NAME OF FATHER: Peter St. Clair

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Idaho State Prison
By J M Cribbins
(Address)

15. Filed Aug 30 1920
D. H. Poole
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1920, to Aug 28 1920, that I last saw him alive on Aug 28 1920 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo Coulter M. D.

19... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lauderdale Cemetery | DATE OF BURIAL: 8/31 1920

20. UNDERTAKER: Schreiber & Pedicord | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2024

File No. 3136

Registered No. 8

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

(No. 6 Miles South West St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Freeman Maxwell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 28 (Day) 1877 (Year)

7. AGE: 42 Yrs. 5 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Jackson Maxwell

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Nancy Thornton

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. F. Maxwell

(Address) Boise Idaho R.F.D. #4

15. Filed 8/25 1920

R. H. Ball
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1917, to Aug 24 1920 that I last saw him alive on Aug 20 1920, and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 10 Yrs. mos. ds.

Contributory (Secondary) Pulmonary hemorrhage

(Duration) yrs. mos. 15 min ds.

(Signed) F. N. Braxtan M. D.

Aug 25 1920 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Liberty, Nebraska — DATE OF BURIAL 19 .....

20. UNDERTAKER: Summers & Kirk — ADDRESS Boise Idy

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31370

Registered No. 3373

1. PLACE OF DEATH

County of Bannock St

City of Pocatello

(No. 1146 W. Wo Garfield St.)

Registration District No. 84

Primary Registration District No. 2101

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irma J Turnbull

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: July (Month) 18 (Day) 1900 (Year)

7. AGE: 19 Yrs. 11 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE: Pocatello (State or Country)

10. NAME OF FATHER: Wm A J Turnbull

11. BIRTHPLACE OF FATHER: Chicago (State or Country)

12. MAIDEN NAME OF MOTHER: Emma Lundberg

13. BIRTHPLACE OF MOTHER: Sweden. (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A J Turnbull

(Address) Pocatello

15. Filed 7-22- 1920

J R Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1920 to ..... 19..... that I last saw h..... alive on July 18 1920 and that death occurred on the date stated above, at 12 Aug P.M.

The CAUSE OF DEATH* was as follows:

Premature.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Young M. D.

July 19 21 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? I

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New cemetery | DATE OF BURIAL: 7/21 1920

20. UNDERTAKER: P.F. Tasker ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

31371 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. 4 miles West Pocatello)

File No. 33

Registered No. 3374

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alta Lovina Grover

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: October 23 1902 (Month) (Day) (Year)

7. AGE: 19 Yrs. 9 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At School

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot

10. NAME OF FATHER: Ernest A. Grover

11. BIRTHPLACE OF FATHER (State or Country): Hooper Utah

12. MAIDEN NAME OF MOTHER: Hanna L Garner

13. BIRTHPLACE OF MOTHER (State or Country): Hooper Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. A. Grover

(Address) Blackfoot

15. Filed 9/19 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental death due to overturning of automobile

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S S Ferguson Coroner M. D.

7-29 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida. DATE OF BURIAL: Aug 1 1920

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31372

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. 736 East Center St.)

File No. 35

Registered No. 3325

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Franklin Harvey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: Dec 3rd 1902 (Month) (Day) (Year)

7. AGE: 17 Yrs. 7 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Delta Col.

10. NAME OF FATHER: Thomas Harvey

11. BIRTHPLACE OF FATHER (State or Country): Yankton S.D.

12. MAIDEN NAME OF MOTHER: Amelia Lambert

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Harvey
(Address) Pocatello Idaho.

15. Filed 8/2 1920 J. R. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1st (Day) 20 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1920, to Aug 1 1920, that I last saw him alive on Aug 1 1920, and that death occurred on the date stated above, at 7.40 P.M.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukaemia
Carcinosis of Liver

(Duration) 0 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Hamner C. Davis M. D.

8/1 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Masonic Cemetery	Aug 5th 1920
20. UNDERTAKER Will T Walker	ADDRESS Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31373

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 35
Registered No. 3376

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 435 No Lincoln St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Lamar Thomas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Infant

6. DATE OF BIRTH: July (Month) 31 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: L. H. Thomas

11. BIRTHPLACE OF FATHER (State or Country): Salt Lake Utah

12. MAIDEN NAME OF MOTHER: Dorothia England

13. BIRTHPLACE OF MOTHER (State or Country): Moreland Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. H. Thomas
(Address) City

15. Filed 9/6 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 31 1920, to Aug. 5 1920, that I last saw him alive on Aug 5 1920 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
premature Birth

(Duration) since Birth Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. N. Thomas M. D.
(Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: Aug 7 20

20. UNDERTAKER: Schumacher & Hill — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31374

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 21
(No. 402 No 3 St.)

File No. 33
Registered No. 3377

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Rogers DeGaus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married
6. DATE OF BIRTH: Feby 11 1887 (Month) (Day) (Year)
7. AGE: 33 Yrs. 6 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): New Orleans, La
10. NAME OF FATHER: David Rogers DeGaus
11. BIRTHPLACE OF FATHER (State or Country): /
12. MAIDEN NAME OF MOTHER: Dicy McGaylord.
13. BIRTHPLACE OF MOTHER (State or Country): /
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Josephine DeGaus
(Address) 1402 N. 8th
15. Filed 8/15 19..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 8th 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 5 1920 to Aug 1 1920
that I last saw h.... alive on Aug 1 1920
and that death occurred on the date stated above, at 3:00 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Am Mentor M. D.
Aug 9 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cem. Pocatello — DATE OF BURIAL: Aug 9 1920
20. UNDERTAKER: [illegible] — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31376

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 35
Registered No. 3379

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 624 W Bros Ave Lat St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joe Gardner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: July 17 1868 (Month) (Day) (Year)

7. AGE: 57 Yrs. 5 Mos. 21 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia Canada

10. NAME OF FATHER: /

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. Gardner
(Address) Bay Horse Ida

15. Filed 8/15 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1920 to Aug 10 1920
that I last saw him alive on Aug 10th 1920
and that death occurred on the date stated above, at 1P A.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Rheumatoid arthritis
(Duration) 4 yrs. ..... mos. ..... ds.

(Signed) Dr Lyman M. D.
8/10 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery
DATE OF BURIAL: 8/12 1920

20. UNDERTAKER: W. T. Tracker
ADDRESS: Pocatello

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31377

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 216
(No. Lynn Bros Hospital St.)

File No. 35
Registered No. 3380

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrl Ranstrom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Child

6. DATE OF BIRTH: August (Month) 25 (Day) 1919 (Year)

7. AGE: — Yrs. 11 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: A. L. Ranstrom

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Virginia Higgins

13. BIRTHPLACE OF MOTHER (State or Country): Iowa Not Given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Ranstrom
(Address) City.

15. Filed 8/15 19 .....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from aug 10th 1920 a.m. to aug 10th p.m. 1920 that I last saw him alive on aug 10th 1920 and that death occurred on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:
Cholera Morbus & sicanitis
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) Prolonged vomiting
(Duration) ..... yrs. 5 mos. ..... ds.

(Signed) C. W. Lynn M. D.
aug 11th 1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View Cem	Aug 12 1920
20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31379

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 84

County of Bannock

Primary Registration District No. 2161

File No. 35

City of Pocatello (No. St. Anthony Hospital)

Registered No. 3381

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Anna E. Cooper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Sept 28 1844
(Month) (Day) (Year)

7. AGE: 59 Yrs. 10 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Davis

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Emma L. Brunsman

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hanna Thomas

(Address) 1361 Elko Ave Pocatello

15. Filed 8/16 1920

J. R. Thomas
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 11 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1920, to Aug 1920
that I last saw h.r alive on Aug 1920
and that death occurred on the date stated above, at 11:40 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 30 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A M Newton M. D.

Aug 14 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View	Aug 15 1920
20. UNDERTAKER	ADDRESS
D. Schumacher & Co	Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31380

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 84

City of Pocatello — Primary Registration District No. 2161 — File No. 35

(No.) St. Anthony Hospital — Registered No. 3383

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Avaline Villalpando

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Mexican	Single

6. DATE OF BIRTH: June 18 (Month) (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. Villalpando

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE

(Informant) A. Villalpando

(Address) Pocatello Idaho

15. Filed 8/16 1920

Registrar

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1920, to Aug 13 1920, that I last saw h— alive on Aug 13 1920, and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Infantile Atrophy (Marasmus) (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Congenital Prematurity (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Sprague M. D.

8-17 1920 (Address) Pocatello.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Evergreen View	Aug 15 1920
20. UNDERTAKER	ADDRESS
Schumacher & Hart	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

31383

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2141
File No. 35
Registered No. 2386

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Lynn Bros Wash St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucas Wm. West
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	white	Widower

6. DATE OF BIRTH: Sept 1st 1856 (Month) (Day) (Year)

7. AGE: 64 Yrs. 11 Mos. ___ ds.
IF LESS than 1 day how many ___ hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Station Agent
(b) General nature of industry, business or establishment in which employed (or employer): O.W.R.R. & N. Co.

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Wm West

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alma Manning
(Address) 225 N. 1st West St.

15. Filed Aug 3 1920 J H Lynn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 1 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 31 1920
that I last saw h... alive on July 31 1920
and that death occurred on the date stated above, at 9:30 M.
The CAUSE OF DEATH† was as follows:
Carcinoma of Tongue
Operation Removal

(Duration) 1 Yrs. 7 mos. ___ ds.
Contributory (Secondary) Emaciation & exhaustion
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J H Lynn M. D.
Aug 1 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ___ yrs. 5 mos. ___ days. In the State ___ yrs. ___ mos. ___ days
Where was disease contracted if not at place of death?
Former or usual residence Heyburn Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Cem	Aug 4 1920

20. UNDERTAKER: McKay Undertaking Co
ADDRESS: Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31384

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 241
File No. 30
Registered No. 3387

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cora Effie Hauser
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Married

6. DATE OF BIRTH
June 11 (Month) 1880 (Day) (Year)

7. AGE
40 Yrs. 1 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER J. T. Jones

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Mandy Hauser

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W. Hauser
(Address) 640 N. Harrison Pocatello Ida

15. Filed Aug 3, 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 2 1920
that I last saw h.r. alive on Aug 2 1920
and that death occurred on the date stated above, at 4:30 A.M.
The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pregnancy
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Aug 3 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 hours mos. days. In the State 3 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Kentucky

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL
Paducah Kentucky Aug 3 1920

20. UNDERTAKER H. L. McHAN
ADDRESS POCATELLO, IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

31385

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 246
File No. 83
Registered No. 5388

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Entgris Castro
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write word): Single

6. DATE OF BIRTH: (Month) (Day) 1885 (Year)

7. AGE: 35 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer on
(b) General nature of industry, business or establishment in which employed (or employer): Section

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Pond at
(Address) General Hospital

15. Filed Aug 3, 1920
J. R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-28-1920 to 8-3-1920
that I last saw h. alive on 8-2-1920
and that death occurred on the date stated above, at 6:15 P.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) F. E. Reed M. D.
8/3 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. 6 days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Mexico

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Aug 1920.
20. UNDERTAKER: H. E. McKan ADDRESS: 215 So Main

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31386

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock. Registration District No. 84

City of Pocatello. Primary Registration District No. 216/

(No. General Hosp. St.) File No. 35-

If death occurs away from usual residence, give facts called for under special information.

Registered No. 3389

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Count Oliver Mavy.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married.

6. DATE OF BIRTH: Sept. (Month) 8 (Day) 1876 (Year)

7. AGE: 44 Yrs. 11 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Station agt.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shriene Ohio

10. NAME OF FATHER: J. V. Mavy.

11. BIRTHPLACE OF FATHER (State or Country): Shriene Ohio

12. MAIDEN NAME OF MOTHER: Minnie Robinson

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles O Mavy
(Address) Bancroft. Idaho

15. Filed Aug 4 1920. [signature] Dep Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 4 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-4 1920 to 8-4 1920 that I last saw h[illegible] alive on 8-4 1920 and that death occurred on the date stated above, at 4.40 M.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

8/5 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Layton Utah

19. PLACE OF BURIAL, REMOVAL: [illegible] DATE OF BURIAL: 1920

20. UNDERTAKER: [illegible] ADDRESS: 215 S. Main

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31388

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33

Registered No. 3391

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. ..., O.S.L. Station St.)

Registration District No. 84

Primary Registration District No. 216

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stepan Mihan.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: Caucassian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: not Known. (Month) (Day) 1 (Year)

7. AGE: 43 Yrs. — Mos. — ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Railroad man

(b) General nature of industry, business or establishment in which employed (or employer): car dept.

9. BIRTHPLACE (State or Country): Turkey

10. NAME OF FATHER: not Known.

11. BIRTHPLACE OF FATHER (State or Country): Greece.

12. MAIDEN NAME OF MOTHER: Katherine —

13. BIRTHPLACE OF MOTHER (State or Country): Greece.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mr. Grant.

(Address) O. S. L. R. R.

15. Filed August 15 1920. J. H. Young, Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 19...

that I last saw h... alive on ... 19...,

and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

accidently struck by car

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...

(Duration) ... yrs. ... mos. ... ds.

(Signed) S. S. Ferguson Coroner M. D.

8-14 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Aug 15 1920

20. UNDERTAKER: H. L. McHan ADDRESS: H. L. McHan Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31389

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 84

Primary Registration District No. 2141

File No. 33

County of Bannock

City of McCammon (No. ..... St.)

Registered No. 3392

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Silvus Pernell Lowe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 17 (Day) 1894 (Year)

7. AGE: 26 Yrs. 2 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Franklin, Idaho

10. NAME OF FATHER: Silvus Lowe

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Elizabeth Pernell

13. BIRTHPLACE OF MOTHER (State or Country): St Louis Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas G. Lowe

(Address) Logan

15. Filed 8-24 1920.

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidentally Burned to death by Drowning Suffocation

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S S Ferguson Coroner M. D.

8-14 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence Logan, Utah

19. PLACE OF BURIAL OR REMOVAL: Logan Utah | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: C. A. Lundquist | ADDRESS Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31390 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 1241
File No. 35
Registered No. 3393

1. PLACE OF DEATH
County of Bannock
City (No. Ward) Pocatello (No. St.) Ward No 2 of City Pocatello
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Viking H Ferguson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 5 (Day) 1911 (Year)

7. AGE: 8 Yrs. 4 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: Oscar Ritzman

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Louisa Olen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar Ritzman
(Address) Pocatello Ida

15. Filed 8/20 1920 J W Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19.., to ..... 19..
that I last saw h.. alive on ..... 19..
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:
Gun Shot Wound
Thru Head
Accidental
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S. S. Ferguson Coroner M. D.
8/20 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 8/22 1920

20. UNDERTAKER: W. Wacker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31391 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello (If outside limits, write "rural")
Registration District No. 84
Primary Registration District No. 2161
(No. 644 North Main St.)
File No. 35
Registered No. 33914

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME W. J. McDonald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: not obtainable (Month) (Day) 1 (Year)
7. AGE: about 25 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: R. R. McDonald
11. BIRTHPLACE OF FATHER (State or Country): not known
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER (State or Country): "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) General information
(Address)
15. Filed 8/28 1920 J. Yanney Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ✓ 19 ✓ to ✓ 19
that I last saw h alive on 19
and that death occurred on the date stated above, at 5-30 P. M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. S. Ferguson Coroner
8/20 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: 8/24 1920
20. UNDERTAKER: T. M. Baker — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31392

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 35
Registered No. 3395

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Linn Apts. Portland St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm J Dean
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: Oct (Month) 3 (Day) 881 (Year)
7. AGE: 38 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Machinist
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ill Elmwood
10. NAME OF FATHER: John J. Dean
11. BIRTHPLACE OF FATHER (State or Country): Penn.
12. MAIDEN NAME OF MOTHER: Margaret C Kinder
13. BIRTHPLACE OF MOTHER (State or Country): Penn.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. J. Dean
(Address) Denver Colo.
15. Filed 8/24 1920 J R Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1920 to Aug 20 1920 that I last saw h~~im~~ alive on Aug 20 1920 and that death occurred on the date stated above, at 1 10 P.M.
The CAUSE OF DEATH* was as follows:
Diabetic Coma -
(Duration) 10 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.
(Signed) J. H. Lynn M. D.
aug 23 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery — DATE OF BURIAL: 8/24 1920
20. UNDERTAKER: W. A. Walker — ADDRESS: Pocatello Ida

FORM V. S. No. 5-A—25 M. 1-19.

Dr. Lynn

CERTIFICATE OF DEATH

31555
31893

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2141

(No. 234 N. 7th St.)

File No. 35

Registered No. 8396

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John M. Fabinzio

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Italian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 2nd 1902
(Month) (Day) (Year)

7. AGE: 17 Yrs. 7 Mos. 18 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Tony Fabinzio

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Josephine Pallotta

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Tony Fabinzio

(Address) 234 N. 7th St.

15. Filed 8/21 1920

J. R. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 20 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19th 1920 to Aug 20 1920 that I last saw him alive on Aug 20th 1920 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Tonsilitis & rheumatism.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Lynn M. D.

Aug 21 1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View

DATE OF BURIAL: Aug 22 1920

20. UNDERTAKER: Schumacher & Hay

ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

J. Lynn 31394

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 30

Registered No. 3897

1. PLACE OF DEATH

County of Bannock Registration District No. 84

City of Pocatello Primary Registration District No. 2161

(No. 623 N. 5th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christ Pulos

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Greek	Single

6. DATE OF BIRTH: June 1st 1919 (Month) (Day) (Year)

7. AGE: 1 Yrs. 1 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Nick Pulos

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Eulia Kamasimos

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nick Pulos
(Address) 623 N. 5th

15. Filed 8/21 1920 J. H. Lynn Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21, 1920 to Aug 21 1920 that I last saw him alive on Aug 21 1920 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Diarrhea — Enteritis —

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) — yrs. — mos. — ds.

(Signed) J. H. Lynn M. D.

Aug 21 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Aug 23 1920

20. UNDERTAKER: Schumacher Bros — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31395 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 35
Registered No. 3402

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. to Pullman, O. S. L. R. R. Yards St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ida Marie Stern

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	white	Married

6. DATE OF BIRTH
Sept (Month) 8 (Day) 1900 (Year)

7. AGE
20 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER C. M. Cline

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Cora Paxton

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Marion W Stern
(Address) Akron Colorado

15.
Filed aug 28 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
aug (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. S. Ferguson Comm M. D.
8/28 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 12 yrs. hours ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Star Idaho

19. PLACE OF BURIAL OR REMOVAL: Akron Colorado — DATE OF BURIAL: aug 28 1920

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 21 1965

JUL 9 1980

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31396

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 35
Registered No. 3303

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lyman Allen Prater

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower

6. DATE OF BIRTH: Nov (Month) 30 (Day) 1859 (Year)

7. AGE: 60 Yrs. 8 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired Railway Mail
(b) General nature of industry, business or establishment in which employed (or employer): Clerk.

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Holley Prater

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Casey

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bonus H. Prater
(Address) POCATELLO, IDAHO

15. Filed Aug 29 1920
J. R. Young. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 15 1920 to July 29 1920
that I last saw h[illegible] alive on July 28 1920
and that death occurred on the date stated above, at 7 a. M.
The CAUSE OF DEATH* was as follows: [illegible]

(Duration) 1 Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. 3 mos. in days. In the State Pocatello yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Salt Lake City Utah

19. PLACE OF BURIAL OR REMOVAL: St Louis Mo.
DATE OF BURIAL: Aug 29 1920

20. UNDERTAKER: McHan Undertaking Co.
ADDRESS: POCATELLO, IDAHO

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31398

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 30
Registered No. 3398

1. PLACE OF DEATH
County of Bannock.
City of Pocatello.
If death occurs away from usual residence, give facts called for under special information.
(No. County Infirmary St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Ralph.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Not known. (Write the word.)

6. DATE OF BIRTH: — (Month) — (Day) 1857 (Year)

7. AGE: 69 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Not Known.

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Sanders.
(Address) County Infirmary

15. Filed Aug 24 1920. J. Young. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 22 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1920 to Aug 22 1920 that I last saw him alive on Aug. 22 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. S. Greene M. D.

Aug 22 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Aug 25 1920

20. UNDERTAKER: H. L. McHan ADDRESS: 215 So Main Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 84 31399 — State of Idaho BOARD OF HEALTH Bureau of Vital Statistics

Primary Registration District No. 2141 — File No. 35

Registered No. 3399

1. **PLACE OF DEATH**

County of Bannock

City of Pocatello (No. 132 N. Grant St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Harold James Ponsiell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Infant (Write the word.)

6. **DATE OF BIRTH** August (Month) 5 (Day) 1920 (Year)

7. **AGE** — Yrs. — Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer): —

9. **BIRTHPLACE** (State or Country) Pocatello

10. **NAME OF FATHER** Chas Ponsiell

11. **BIRTHPLACE OF FATHER** (State or Country) Robin Ida.

12. **MAIDEN NAME OF MOTHER** Elnora D Hamp

13. **BIRTHPLACE OF MOTHER** (State or Country) Lewiston Utah.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Chas Ponsiell

(Address) Mc Cammon

15. Filed 8/23 1920

J. H. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** August (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1920 to Aug 23 1920 that I last saw h— alive on Aug 23 1920 and that death occurred on the date stated above, at 1:30 p M.

The CAUSE OF DEATH* was as follows:

Inanition Premature 7 mo Gestation

(Duration) Yrs. — mos. 18 ds.

Contributory (Secondary) Inanition

(Duration) yrs. — mos. 18 ds.

(Signed) W. J. Howard M.D.

8/23 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** McCammon Idaho — **DATE OF BURIAL** Aug 19 20

20. **UNDERTAKER** Schumacher & Hall — **ADDRESS** Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

31400

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2141
File No. 35
Registered No. 3400

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Fire Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Little
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Italian	Single

6. DATE OF BIRTH Nov 9th 1905
(Month) (Day) (Year)

7. AGE 14 Yrs. 8 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Nevada

10. NAME OF FATHER Dan Little

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Florence Cannonico

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dan Little
(Address) 559 Railroad ave

15. Filed 9/24 1920
Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 14 1920 to Aug. 22 1920
that I last saw h[illegible] alive on Aug. 22 1920
and that death occurred on the date stated above, at 7:30 P.M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
Tuberculosis

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Pneumonia (Grippe)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
9/24 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Fairmount View — DATE OF BURIAL Aug 25 1920

20. UNDERTAKER Schwendiman Bros — ADDRESS City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—[illegible]

CERTIFICATE OF DEATH

31401

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 35
Registered No. 3401

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.
(No. 1800 Taft Avenue St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lavell Crane Sainsbury

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: October 15 1918 (Month) (Day) (Year)

7. AGE: 1 Yrs. 10 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: Guy Sainsbury

11. BIRTHPLACE OF FATHER (State or Country): Arizona

12. MAIDEN NAME OF MOTHER: Sarah E Hodgson

13. BIRTHPLACE OF MOTHER (State or Country): Preston Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Guy Sainsbury
(Address) 1860 Taft Ave

15. Filed 8/28 1920
J R Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 28 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 23 1920 to Aug. 28 1920
that I last saw h. alive on Aug 27 1920
and that death occurred on the date stated above, at 3 a M.
The CAUSE OF DEATH* was as follows:
Ileo-colitis
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) ✓
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. F. Howard M. D.
8/28 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Layton Utah — DATE OF BURIAL: Aug 30 1920
20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

3148

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
File No.
Registered No. 16

1. PLACE OF DEATH.
County of Bannock
City of Grace (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dale Eglert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: whit
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. April 27 (Month) (Day) 1917 (Year)

7. AGE: 2 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) None

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Rube Eglert

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Eglith Eden Stoddard

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs James Green
(Address) Grace . Idho

15.
Filed Aug 7, 1920 Ecis Kegley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sep. (Month) 6, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25, 1920, to Sep 6, 1920, that I last saw her alive on Sep 5, 1920, and that death occured on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:
Ulceration Cecilis

(Duration) Yrs. mos. 36 ds.
Contributory (Secondary) Pertussis
(Duration yrs. 2 mos. ds.

(Signed) Ecis Kegley M. D.
9/7/1920 (Address) Soda Springs Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grace, Idaho
DATE OF BURIAL: Sep 9, 1920

20. UNDERTAKER: None
ADDRESS: —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No.
(No. , St.)

File No. 31403
Registered No. 21

1. PLACE OF DEATH
County of Benewa
City of De Smet
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Libby
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: 12 (Month) 16 (Day) 1913 (Year)

7. AGE: 6 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wash.

10. NAME OF FATHER: Charlie Libby

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Sadie Bride

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Libby
(Address) Sanders Idaho

15.
Filed 19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 1 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25 1920, to Aug 1 1920, that I last saw her alive on July 30 1920 and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(Duration) 6 Yrs. 7 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C B Belyea M. D.

19 (Address) Tekoa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 6 yrs. mos. days. In the State 6 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Golden Rod Tekoa — DATE OF BURIAL: 8-3 1920

20. UNDERTAKER: C L Schuberud — ADDRESS: Tekoa Wn

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 1 31404

Registered No. 23

1. PLACE OF DEATH

County of Benewah

City of Desmet

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 31

Primary Registration District No.

(No. , St.)

2. FULL NAME Prosper Percy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	Indian	single

6. DATE OF BIRTH

(Month) (Day) 1902 (Year)

7. AGE

18 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Desmet Ida

10. NAME OF FATHER Thomas Prosper

11. BIRTHPLACE OF FATHER (State or Country) Desmet, Ida

12. MAIDEN NAME OF MOTHER Mary Joseph

13. BIRTHPLACE OF MOTHER (State or Country) Desmet, Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary Prosper

(Address) Desmet, Ida

15.

Filed Aug 7 1920 J. L. Bihan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Tuberculosis of the lower nephrites

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) B. C Clizer M. D.

19..... (Address) Tekoa, Wash.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Desmet

DATE OF BURIAL Aug 8 1920

20. UNDERTAKER J. Falcon

ADDRESS Desmet

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... , ... St.)

File No. 31405
Registered No. 42

1. PLACE OF DEATH

County of Benewah
City of St Maries

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christofer L. Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug. (Month) 24 (D.) 1920 (Year)

7. AGE: ... Yrs. ... Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Julius C Larson

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Grace Mateas

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julius C Larson
(Address) Benewah

15. Filed Aug 28 1920
H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24, 1920, to Aug 28 1920 that I last saw h. ~~was~~ alive on Aug 28 1920, and that death occurred on the date stated above, at 9 A. M.
The CAUSE OF DEATH* was as follows:
Premature Birth
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) C B Smith M. D.
Aug 28 1920 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 8/29 1920
20. UNDERTAKER: H E Hunt Co — ADDRESS: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK + THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 31406
Registered No. 41

1. PLACE OF DEATH

County of Benewah
City of St Maries
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sylvia D. Casey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 26 (Day) 1894 (Year)

7. AGE: 25 Yrs. 9 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Allen L. Kromer

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Jessie M. Priest

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr Margaret Kromer
(Address) Hilleja Mart

15. Filed Aug 27 1920 H E Hunt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1920 to Aug 25 1920 that I last saw her alive on Aug 25 1920, and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:

Septico-pyaemia

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

8/27 1920 (Signed) R E Bonnwell M. D.
(Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Joseph cemetery — DATE OF BURIAL: 8/28 1920
20. UNDERTAKER: H E Hunt Co — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31407

1. PLACE OF DEATH

County of Bannock
Registration District No. 32
Primary Registration District No. 2049
City of ..... (No. ....., ... St.)
Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Sutton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE
About 50 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H L Adams
(Address) .....

15.
Filed Aug. 26 1920 H E Hunt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from X 19..., to X 19...,
that I last saw h... alive on X 19...,
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Gun Shot Wound.

..... (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....
..... (Duration) ... yrs. ... mos. ... ds.

(Signed) H L Adams Coroner
Aug 26 1920 (Address) St Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	8-26 1920

20. UNDERTAKER	ADDRESS
H E Hunt Co	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31408

Registered No. 39

1. PLACE OF DEATH

County of Bonneville — Registration District No. 32

City of Harrison Flats — Primary Registration District No. 2049

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillian Lee.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	Single

6. DATE OF BIRTH: Aug. (Month) 12 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many — hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: X

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. Lee.

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lillian Fellows

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): C Lee

(Address): St. Maries

15. Filed Aug 13 1920 — J. E. Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1920 to Aug 12 1920 that I last saw h— alive on Aug 12 1920 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C B Smith M. D.

8/13 1920 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wood Lawn	8/13 1920

20. UNDERTAKER	ADDRESS
J. E. Hunt Co	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31409 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
(No. ..... , ... St.)
File No. 3
Registered No. 34

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Letitia Parsons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Nov (Month) 22 (Day) 1919 (Year)

7. AGE ..... Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Parsons

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Virginia Reese

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Nellie Parsons
(Address): Sterling Ida

15. Filed Aug 4 20 1920 M. E. Martineau Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h— alive on ..... 191...,
and that death occured on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
an automobile accident—
fracturing skull—

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Jas. C. Martineau M. D.
8/4 1920 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sterling Ida — DATE OF BURIAL: 8/4 1920

20. UNDERTAKER: Friends — ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31410

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12

Primary Registration District No. .....

(No. .... St.)

File No. .....

Registered No. 88

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura England

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: June (Month) 22 (Day) 1855 (Year)

7. AGE: 75 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Copenhagen Denmark

10. NAME OF FATHER: Niels Thueson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John England

(Address) Moreland

15. Filed Aug 6 19 20 Mrs Nellie E. Pierce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 3 1920, to August 5 1920, that I last saw her alive on August 4 1920, and that death occurred on the date stated above, at 2.25 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) — Yrs. — mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

8/6 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moreland Cemetery — DATE OF BURIAL: Aug 1920

20. UNDERTAKER: Ed L Egle — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31411
Registered No. 89

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
Registration District No. 121
Primary Registration District No. 2194
(No. Idaho Insane Asylum St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Maggie O'Brien Young

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: unknown (Month) 1 (Day) (Year)
7. AGE: unknown yrs. mos. ds.
IF LESS than 1 day how many hrs. or min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Ireland
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER (State or Country): unknown
12. MAIDEN NAME OF MOTHER: unknown
13. BIRTHPLACE OF MOTHER (State or Country): unknown
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Institution Records Martha C. High - Clerk & Bookkeeper
(Address) Blackfoot, Ida.
15.
Filed Aug 8 1920 Mrs Nellie E. Faber Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 7, 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY That I attended deceased from March 12 1920, to Aug. 7 1920
that I last saw her alive on Aug 7 1920
and that death occurred on the date stated above, at 11:15 A.M.
The CAUSE OF DEATH* was as follows:
Status Epilepticus
(Duration) yrs. mos. 3 ds.
Contributory (Secondary) Epilepsy Nocturnal
(Duration) 8 yrs. 6 mos. — ds.
(Signed) C. A. Jones M. D.
Aug. 7 1920 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 8 yrs. 3 mos. 12 ds.
In the unknown State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence Boise, Ada County, Idaho.

19. PLACE OF BURIAL ~~OR REMOVAL~~: Cayuse Cemetery
DATE OF BURIAL: Aug. 7 1920
20. UNDERTAKER: Chas Wright - Emp.
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31412

Registered No. 96

1. PLACE OF DEATH

County of Bingham

City of Blackfoot (No. RFD 3 St.)

Registration District No. 121

Primary Registration District No. 2194

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Conradena Tillen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 24 (Day) 1898 (Year)

7. AGE: 22 Yrs. 3 Mos. 13 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Chas J. Gerdes

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Anna C Bishop

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Emma C Gerdes

(Address) Blackfoot Ida.

15. Filed Aug 9 1920 Mrs Nadine E. Peterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 8th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/1 1920 to 8/7 1920 that I last saw her alive on 8/7 1920 and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows: Thrombosis of branch middle cerebral artery

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J O Hamptan M. D.

8/8 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hyrum Utah — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: E J Funk — ADDRESS Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 31414
Registered No. 99

1. PLACE OF DEATH

County of Bingham
City of Blackfoot
(No. R F D 2 St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Pearson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 15 (Day) 1920 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bingham Co Idaho

10. NAME OF FATHER: Burt Pearson

11. BIRTHPLACE OF FATHER (State or Country): Ino

12. MAIDEN NAME OF MOTHER: Marguerite Page

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burt Pearson
(Address) Blackfoot Ida

15. Filed Aug 17 1920 By Mrs Thelma E. Palmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1920 to Aug 16 1920 that I last saw h[illegible] alive on Aug 16 1920 and that death occurred on the date stated above, at 8. P. M.
The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) ....Yrs. ....mos. 1 ds.

Contributory (Secondary) —

(Duration) ....yrs. ....mos. ....ds.

(Signed) F. W. Mitchell M. D.
8/16 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Rupade — DATE OF BURIAL: Aug 17 1920

20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 219
File No. 31415
Registered No. 44

1. PLACE OF DEATH
County of Bingham
City of Ter
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Mamie Burley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: August (Month) 20 (Day) 1900 (Year)

7. AGE: ..... Yrs. X Mos. ..... ds.
IF LESS than 1 day how many 16 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: X
(b) General nature of industry, business or establishment in which employed (or employer): X

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. A. Burley

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mamie M Bruce

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Burley
(Address) Blackfoot Ida

15. Filed Aug 24 1920 Mrs Nalia E. Paine
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1920 to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
premature about 7 mo
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. D. Hampton M. D.
8/24 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ft Hall Indian Res
DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: L. N. Burley
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31416

Registered No.

1. PLACE OF DEATH

Registration District No.

Primary Registration District No.

County of Bingham

City of Blackfoot (No. Blackfoot Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles B Whitman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 31 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Byrd Whitman

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Mary Jane Hill

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Byrd Whitman

(Address) Rigby R 3

15. Filed Aug 20 1920 Mr Nelson E Paine Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to August 19 1920 that I last saw h.. alive on August 19 1920, and that death occurred on the date stated above, at 6. A. M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W Mitchell M. D.

8/20 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lorenzo Idaho

DATE OF BURIAL 19

20. UNDERTAKER: E J Funk

ADDRESS Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2022
File No. 31418
Registered No. 36

1. PLACE OF DEATH.
County of Blaine
City of Bellevue (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Proctor.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow.

6. DATE OF BIRTH. Dec (Month) 16th (Day) 1840 (Year)

7. AGE: 79 Yrs. 8 Mos. 1 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeping
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland.

10. NAME OF FATHER: Robert Taylor.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Ann Coldclough.

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E Louise Wilson
(Address) Bellevue Ida.

15. Filed 8-30 1920 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

Butler.

16. DATE OF DEATH: Aug. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1920, to Aug 17 1920, that I last saw h.er alive on Aug 16 1920 and that death occured on the date stated above, at 9a. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Infection of the Lung.
(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) L. R. Butler M. D.
Aug 17 1920 (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Scaforth, Ontario Canada
DATE OF BURIAL 191

20. UNDERTAKER: R. D. Harris
ADDRESS Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31419

Registration District No. 78

Primary Registration District No. 2155

(No. ..... St.)

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Susana Montague

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	single

6. DATE OF BIRTH: Aug (Month) 29 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Joseph Montague

11. BIRTHPLACE OF FATHER (State or Country) Michigan

12. MAIDEN NAME OF MOTHER Elizabeth Syler

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Montague

(Address) Sandpoint

15. Filed Sept 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1920, to Sept 2 1920, that I last saw her alive on Sept 1 1920, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

prolonged labor

..... (Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. R. Wallentine M. D.

9-2 1920 (Address) Sandpoint

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint	9-2-1920

20. UNDERTAKER	ADDRESS
D. I. Sayer	Sandpoint, Ida

MARGIN RESERVED FOR BINDING.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 31420
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Kooteani
If death occurs away from usual residence, give facts called for under special information.

(No. Kooteani, Ida. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marion B. Larson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Aug. (Month) 5 (Day) 1920. (Year)

7. AGE: ...Yrs. ...Mos. 3 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: W.W. Larson.

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Madeline Allebough.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W.W. Larson.
(Address) Kooteani, Ida.

15. Filed Sept 8 1920 FLOYD G. WENDLE Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1920 to Aug 8 1920 that I last saw h...er alive on Aug 8 1920, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Premature Birth - (8 mo)

...(Duration) ...Yrs. ...mos. ...ds.

Contributory (Secondary)

...(Duration) ...yrs. ...mos. ...ds.

(Signed) C. P. Staecheli M. D.
Aug. 9. 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint, Ida.	Aug. 9, 1920.
20. UNDERTAKER	ADDRESS
B.W. PUGH.	SANDPOINT, IDA.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31421
Registered No.

1. PLACE OF DEATH

Registration District No. 78
Primary Registration District No. 2/55-

County of Bonner
City of Sandpoint (No. City Hospital. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME May Leitha Smith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: Mar. (Month) 15 (Day) 1899 (Year)

7. AGE: 21 Yrs. 4 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: J.C. Creed.

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Jennie Loney.

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J.C. Creed.
(Address) Sagle, Ida.

15. Filed Sept 8 19.....

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 6 (Day) -20 19..... (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1920, to Aug 6 19 20, that I last saw h...er alive on Aug 6 19 20, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Suicide - by cutting throat with razor -

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Staencours M. D.

Aug. 9. 19 20. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 3 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Sagle, Ida.

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida.
DATE OF BURIAL: Aug. 9, 1920.

20. UNDERTAKER: B.W. PUGH.
ADDRESS: SANDPOINT. IDA.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31422

Registration District No. 78
Primary Registration District No. 2133
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Samuels, Ida.
(No. Samuels, Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anthony M. Doyle.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: Aug. (Month) I, (Day) 1847 (Year)

7. AGE: 73 Yrs. Mos. 16 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer): In Woods

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Jamws Doyle

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Betsie Vert

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Doyle Bros
(Address): Samuels, Ida.

15. Filed Sept 8 1920 — FLOYD G. WENDLE, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 16. (Day) -20. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw him alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Carcinoma Pharynx.
did not attend above only
diagnosed Case & Pneumonia Hopeless
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. T. Anderson. M. D.
Aug 17 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Colburn, Ida. | DATE OF BURIAL: Aug. 18, 1920.

20. UNDERTAKER: B.W.PUGH. | ADDRESS: SANDPOINT. IDA.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31423

1. PLACE OF DEATH

County of Bonner Registration District No.

Primary Registration District No.

City of Laclede (No. Laclede, Ida. St.) Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Bentley Whiting White.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: June (Month) 15, (Day) 1863. (Year)

7. AGE: 57 Yrs. 2 Mos. 14 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): At Home

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: Loraine Whiting.

11. BIRTHPLACE OF FATHER (State or Country): Conn.

12. MAIDEN NAME OF MOTHER: Celesta Lewis.

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C.A.White.

(Address) Laclede, Ida.

15.

Filed 19

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 29, (Day) -20 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920 to Aug 29" 1920 that I last saw her alive on Aug 29 1920, and that death occurred on the date stated above, at 3.30 A.M.

The CAUSE OF DEATH* was as follows:

Uraemic Poisoning

(Duration) Yrs. 6 mos. — ds.

Contributory (Secondary) Pernicious Anaemia

(Duration) 4 yrs. — mos. — ds.

(Signed) F.W.Didier M. D.

Aug, 30, 19 20. (Address) Laclede, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: LACLEDE. IDA. DATE OF BURIAL: AUG. 30 1920

20. UNDERTAKER: B.W.PUGH. ADDRESS: SANDPOINT. IDA.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31425
Registered No. 126

1. PLACE OF DEATH.
County of Bonneville Registration District No. 73
City of Idaho Falls (No. ..... St.) Primary Registration District No. 2110

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Donald Casper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Aug (Month) 15 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Falls Ida

10. NAME OF FATHER: Ira N Casper

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: C. Zoe Courtner

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Carrie N. Casper
(Address) Idaho Falls

15. Filed Aug 26 1920 W Rummond Local Registrar
per Spencer

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h[im] alive on Aug 18 1920,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Unknown
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H R Brunell M. D.
Aug 20 (Address) Idaho Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 8/18/1920

20. UNDERTAKER: C C Dunwoody — ADDRESS: Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31426

Registered No. 12 V -

1. PLACE OF DEATH

County of Bonneville

City of Ida Falls

(No. ..... St.)

Registration District No. 73

Primary Registration District No. 21 V 0

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Henry Gildersleeve

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 9 (Day) 1875 (Year)

7. AGE: 45 Yrs. 3 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: George Gildersleeve

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. James H Gildersleeve

(Address) Idaho Falls

15. Filed Aug 24 19 20 W Kennard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 2 1920 that I last saw him alive on Aug 2 1920. and that death occurred on the date stated above, at 7 30 PM

The CAUSE OF DEATH* was as follows:

Hemorrahge of Stomach

(Duration) ——— Yrs. ——— mos. 6 hrs ds.

Contributory (Secondary) Carcinoma of Stomach

(Duration) 2 yrs. 1 mos. ——— ds.

(Signed) Jabez Mad M. D.

19 20 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 8/5 19 20

20. UNDERTAKER: C C Dierwoodey — ADDRESS: Ida Falls

Dr Heat.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31427

Registered No. 124

Registration District No. 73

Primary Registration District No. 2110

(No. ..... St.)

1. PLACE OF DEATH.

County of Bannock

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Mann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH. March 4 (Month) (Day) 1859 (Year)

7. AGE: 61 Yrs. 5 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work... At Home

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Jonathan Davies

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Jane Cole

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Lew B Mann

(Address) Idaho Falls

15. Filed Aug 26 1920 W Hammond Local Registrar

D McCauley

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16th 1920, to Aug 16 1920, that I last saw her alive on August 16th 1920, and that death occured on the date stated above, at 8.40 P.M.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Chronic Stomach Trouble

(Duration 25 yrs. ..... mos. ..... ds.

(Signed) Andrew McCauley M. D.

8/26 1920. (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 8/28 1920

20. UNDERTAKER: [illegible] — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 1-0
File No. 31428
Registered No. 123

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
If death occurs away from usual residence, give facts called for under special information.

(No. ..... , ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elmer Laue Cramer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: Apr (Month) 23 (Day) 1899 (Year)
7. AGE: 21 Yrs. 4 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming & Student
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Peter Cramer
11. BIRTHPLACE OF FATHER (State or Country): Denmark
12. MAIDEN NAME OF MOTHER: Anna C Laue
13. BIRTHPLACE OF MOTHER (State or Country): Germany
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Peter Cramer
(Address) Ucon Ida
15. Filed Aug 24 1920 W Hummel Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
accidental - Struck by Lightning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C E Dunwoody M.D.
8/3 1920 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ucon Ida — DATE OF BURIAL: 8/4 1920
20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
File No. 31429
Registered No. 123

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fanny Jenkins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: August 2 1893 (Month) (Day) (Year)

7. AGE: 26 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Franklin D. Robbins

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emeline Potter

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Franklin D. Robbins
(Address) Hemenway Idaho

15. Filed July 26 1920 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1920, to July 30 1920
that I last saw h.. alive on July 30 1920
and that death occurred on the date stated above, at 4:30 P. M.
The CAUSE OF DEATH* was as follows:

Puerperal Septicemia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
July 31 1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 12 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Hemenway Idaho

19. PLACE OF BURIAL OR REMOVAL: Hemenway Idaho | DATE OF BURIAL: July 30 1920

20. UNDERTAKER: [illegible] Dimmock | ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
File No. 31430
Registered No. 121

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Norma Roella Bradbury

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: May (Month) 10 (Day) 1911 (Year)

7. AGE: 9 Yrs. 0 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Seattle Wash

10. NAME OF FATHER: S. H. Bradbury

11. BIRTHPLACE OF FATHER (State or Country): Wyo.

12. MAIDEN NAME OF MOTHER: Helen Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. H. Bradbury
(Address) Idaho Falls

15. Filed Aug 26 1920 W. Kunard
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1920 to May 27 1920 that I last saw h.. alive on 27 May 1920 and that death occurred on the date stated above, at 1.10 P.M.
The CAUSE OF DEATH* was as follows:
Diphtheria
.....
.....
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Nephritis
(Duration) ..... yrs. ..... mos. 7 ds.
(Signed) H. D. Gunkin M. D.
5/28 1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 5/28 1920

20. UNDERTAKER: C. C. Dunwoody — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
(No. ..... St.)

File No. 31431
Registered No. 120

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis L Campbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1902 (Year)

7. AGE: 17 Yrs. 8 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ?

10. NAME OF FATHER: N. C. Campbell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Minerva E Durell

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arnold Campbell
(Address) Ozone, Ida

15. Filed Aug 26 19 20 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Accidental - Crushed in a gravel pit

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Dunwoody M.D.
6/26 1920 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ozone Ida
DATE OF BURIAL: 6/27 1920

20. UNDERTAKER: E E Dunwoody
ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21-0
File No. 31432
Registered No. 119

1. PLACE OF DEATH.
County of Bannock
City of Ida Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Grant J King

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Dec (Month) 8 (Day) 1918 (Year)

7. AGE: 1 Yrs. 8 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: J. E. King

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mabel R Clark

13. BIRTHPLACE OF MOTHER (State or Country): Arizona

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J E King
(Address) R D 3 — Ida

15. Filed Aug 26 1920 W. O. [illegible] Local Registrar

BYNS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) E E Linwoodey M. D.

8/14 1920 (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: Aug 15 1920

20. UNDERTAKER: E E Linwoodey — ADDRESS: Ida Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2150
File No. 31433
Registered No. 114

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Burton Howard Cox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: November 2 1870 (Month) (Day) (Year)

7. AGE: 1 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Burt N. Cox

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Evelyn V. McKeighan

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Burt N. Cox
(Address): Fremont Iowa

15. Filed Aug 13 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1920 to Aug 13 1920 that I last saw him alive on Aug 13 1920 and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Acute Hypostatic Pneumonia

10 (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
Aug 13 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. 10 days
Where was disease contracted if not at place of death?
Former or usual residence: Fremont Iowa

19. PLACE OF BURIAL OR REMOVAL: Sugar Pine Cemetery | DATE OF BURIAL: August 15 1920

20. UNDERTAKER: [illegible] | ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7

Primary Registration District No. 21 [illegible] 20

File No. 31434

Registered No. 1 1 7

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls (No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frederick Carter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH April 21 1862
(Month) (Day) (Year)

7. AGE 58 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Charles Carter

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elizabeth Aston

13. BIRTHPLACE OF MOTHER (State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Carter
(Address) Idaho Falls

15. Filed Aug 12 1920 [signature] Local Registrar

SYNC-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August 6 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 4 1920 to August 6 1920 that I last saw him alive on August 6 1920 and that death occurred on the date stated above, at 1:50 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia
(Recording to history)
(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Myocarditis
(Duration) unknown yrs. ..... mos. ..... ds.

(Signed) Geo. L. Willcox M. D.

8/8/ 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State 30 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Ryburg Idaho

Former or usual residence Ryburg Idaho

19. PLACE OF BURIAL OR REMOVAL Rose Hill Cemetery Idaho Falls DATE OF BURIAL Aug 8 1920

20. UNDERTAKER Taylor-Stevenson Undo ADDRESS Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31435.
Registered No. .....

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 74.
Primary Registration District No. 2156.
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Alexander Avery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Infant

6. DATE OF BIRTH. April (Month) 11 (Day) 1920 (Year)

7. AGE ..... Yrs. 3 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Alexander Avery

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Mabel Anna Lewis

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alexander Avery
(Address) Bonners Ferry Ida

15.
Filed ..... 191....
..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... Aug (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920 to Aug 8 1920
that I last saw h[illegible] alive on Aug 8 1920.
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ..... Yrs. 2 mos. — ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. T. Crockett M. D.
Aug 31. 1920. (Address) Bonners Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Bonners Ferry Ida — DATE OF BURIAL Aug. 10.... 1920

20. UNDERTAKER M. Stookey — ADDRESS Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31456
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 79
Primary Registration District No. 21-5-6
(No. ....., ... St.)

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alonzo Carl Johnston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan (Month) 8 (Day) 1888 (Year)

7. AGE: 32 Yrs. 7 Mos. 18 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Charles G. Johnston

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Hedvig S Johnsen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Ellen A. Greenwood
(Address) Salt Lake Utah

15. Filed Aug. 27th 1920. E. E. Fry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 5th 1920, to Aug. 26, 1920, that I last saw him alive on Aug. 17th 1920, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of jaw

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary): Epithelioma of lip (Removed)

(Duration) 2 Yrs. ..... mos. ..... ds.

(Signed) E. E. Fry M. D.
8/27/1920 (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Idaho — DATE OF BURIAL: Aug 28 1920

20. UNDERTAKER: O. B. Cooley — ADDRESS: Bonners Ferry Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2003
File No. 31437
Registered No. 116

1. PLACE OF DEATH

County of Canyon
City of Caldwell
(No. 3rd & Galveston St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Tracey Oscar Dement

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April 30th (Month) (Day) 1916 (Year)

7. AGE: 4 Yrs. Mos. 4 ds. 9

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER: Oscar Dement

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER: Ocea Cookson

13. BIRTHPLACE OF MOTHER (State or Country) Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Oscar Dement Caldwell Ida

15. Filed Sept. 9 1920 John S. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1920, to Sept 9 1920 that I last saw him alive on Sept 9 1920 and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary) Whooping cough

(Duration) yrs. mos. 4 ds.

(Signed) F D Montgomery M. D.

Sept 9 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Sept 10 1920

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1003
File No. 31438
Registered No. 113

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. Cor 10th & Freeport St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie Richards
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 11 (Day) 1871 (Year)

7. AGE: 48 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Will Keeps

11. BIRTHPLACE OF FATHER (State or Country): Tipy Buttler

12. MAIDEN NAME OF MOTHER: Ky

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) G. H. Garner

15. Filed Sept 2 1920
Caldwell Idaho
John L. Morgan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1920, to July 7 1920, that I last saw her alive on July 7 1920, and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of the right orbit
(Duration) Yrs. 6 mos. 10 ds.
Contributory (Secondary) Maxillary sinusitis
(Duration) 7 yrs. mos. ds.
(Signed) J. W. Montgomery M. D.
9-2-1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Sept 2 1920

20. UNDERTAKER: Base Funeral Co — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Canyon

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31439

Registered No. 114

1. PLACE OF DEATH

County of Canyon

City of Caldwell

(No. ..... St.)

Registration District No. 3

Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. W Christie,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: Feb 22 (Month) (Day) 1882 (Year)

7. AGE: 38 Yrs. 6 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: Geo. Christie

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E E Powell

(Address) Vale Oregon

15. Filed Sept 1st 1920

John L Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1920, to Sept 1 1920, that I last saw h. / was alive on Aug 31 1920 and that death occurred on the date stated above, at 5-40 P.M.,

The CAUSE OF DEATH* was as follows:

Bronchial asthma

.....

.....

.....(Duration) ..... Yrs. 4 mos. ..... ds.

Contributory (Secondary) Flu

.....(Duration) ..... 1 yrs. 2 mos. ..... ds.

(Signed) F. D. Forrey M. D.

9/1 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: Sept. 2 1920

20. UNDERTAKER: V Peckham ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

28 M

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

Registration District No. 3
Primary Registration District No. 2005
File No. 31440
Registered No. 113

County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Winfield Scott Janes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: Aug (Month) 3 (Day) 1842 (Year)

7. AGE: 78 Yrs. — Mos. 22 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: Joseph Janes.

11. BIRTHPLACE OF FATHER (State or Country): Don't know.

12. MAIDEN NAME OF MOTHER: Mary Violeta Mulnap.

13. BIRTHPLACE OF MOTHER (State or Country): Don't know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. S. Janes
(Address) Elk, Wash.

15. Filed 8-25-1920 John G. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 19.., to Aug 24 19.., that I last saw h.. alive on Aug 24 19.., and that death occurred on the date stated above, at 3..

The CAUSE OF DEATH* was as follows:
Heart failure

(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary): Paralysis
(Duration) 10+ yrs. ..... mos. ..... ds.

(Signed) S. B. Dudley M. D.
Aug 24 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roswell Cemetary — DATE OF BURIAL: 8-26 1920

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31411

Registration District No. 3

Primary Registration District No. 2005

Registered No. 112

1. PLACE OF DEATH

County of Owyhee

City of Homedale

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Garnet Benson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	white	single (Write the word.)

6. DATE OF BIRTH: October (Month) 1 (Day) (Year)

7. AGE: 11 Yrs. ~ Mos. ~ ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Clark Benson

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Charlott Dealy

13. BIRTHPLACE OF MOTHER (State or Country): Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clark Benson

(Address) Homedale Ida

15. Filed Aug-25-1920 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 23 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1920 to Aug 23 1920 that I last saw h.. alive on Aug 23 1920 and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Simeon Hopper M. D.

19..... (Address) Homedale Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	8-26 1920
20. UNDERTAKER: C. V. Peckham	ADDRESS: Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. I 3
Primary Registration District No. 2005
File No. 31442
Registered No. 111

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Kendall
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	married

6. DATE OF BIRTH
Feb 23 (Month) (Day) 1855 (Year)

7. AGE
65 Yrs. 6 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Dallas Co Iowa

10. NAME OF FATHER Ivy M. Kendall

11. BIRTHPLACE OF FATHER (State or Country) Green Co Ohio

12. MAIDEN NAME OF MOTHER Emily C. Dabney

13. BIRTHPLACE OF MOTHER (State or Country) Vermillion Co Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs H. H. Kendall
(Address) Caldwell Ida

15.
Filed Aug 24 1920 John L. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 10 1920, to Aug 23 1920, that I last saw h.im. alive on Aug 23 1920, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia
Dimal
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. McGee M. D.
8/23 1920 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Central City Nebraska	19 .....
20. UNDERTAKER C. V. Peckham	ADDRESS Caldwell, Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 2005

(No. ..... St.)

File No. 31443

Registered No. 110

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin F. West

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1881 (Year)

7. AGE: 38 Yrs. 10 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Alfred West

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Sarah M. Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah M West

(Address) Caldwell Ida.

15. Filed 8-21-1920 John V. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 20 1920, to Aug 20 1920

that I last saw h. l. M alive on Aug 20 1920

and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia Acute

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. L. Stover M. D.

Aug 21 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: 8/23 19..

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

cola

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 3144
Registered No. 109

1. PLACE OF DEATH

County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glenn G. Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	

6. DATE OF BIRTH June 16 1919
(Month) (Day) (Year)

7. AGE 1 Yrs. 2 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Glenn J. Miller

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Cora B. Datson

13. BIRTHPLACE OF MOTHER (State or Country) ~~Indiana~~ Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Glenn J Miller
(Address) Caldwell Ida #3

15. Filed Aug 21 1920 John L. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 19 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1920 to Aug 19 1920
that I last saw her alive on Aug 18 1920
and that death occurred on the date stated above, at 8-45 A.M.
The CAUSE OF DEATH* was as follows:
Uremia - Coleitis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Peckham M. D.
8/20 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	Aug 22 1920
20. UNDERTAKER F. V. Peckham	ADDRESS Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 31445
Registered No. 108

1. PLACE OF DEATH

County of Oneida
City of Claytonia
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jack Grosdidier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
23 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Don't know.

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER
(State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER
(State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo LaDelle
(Address) Claytonia, Idaho

15.
Filed Aug. 18 1920
John S. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1920, to 1920
that I last saw h.was alive on Aug 16 1920
and that death occurred on the date stated above, at 5:30 P. M.
The CAUSE OF DEATH* was as follows:
Perforation of Stomach
8

(Duration) Yrs. mos. 2 ds.
Contributory (Secondary) Ulcer of Stomach
(Duration) yrs. not known mos. ds.

(Signed) [illegible] M. D.
8/17 1920 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Auburn, Wash. | DATE OF BURIAL 1920

20. UNDERTAKER C. V. Sharp | ADDRESS Caldwell Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31446

Registered No. 107

1. PLACE OF DEATH

County of Canyon

City of Caldwell

(No. ....., ... St.)

Registration District No. 3

Primary Registration District No. 2005

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jimmie Rupe

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	single

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE 66 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Samuel Rupe

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. Rupe

(Address) .....

15. Filed Aug. 14 1920 John L. Imeyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH August (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9 1920, to Aug 12 1920 that I last saw him alive on Aug 12 1920 and that death occurred on the date stated above, at 6:30 A.M.

The CAUSE OF DEATH* was as follows:

Hematuria probably from tubercular kidney

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) several yrs. ..... mos. ..... ds.

(Signed) J. W. Lee M. D. M. D.

8/14 1920 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	8-14 1920

20. UNDERTAKER	ADDRESS
C. V. Peckham	Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 31447
Registered No. 106

1. PLACE OF DEATH

County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hattie L Baker.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	widow

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Missouri.

10. NAME OF FATHER Griffin

11. BIRTHPLACE OF FATHER (State or Country) Kentucky.

12. MAIDEN NAME OF MOTHER Lucas.

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H. F. Baker

(Address) Boise Idaho

15. Filed Aug. 13 - 1920 John L. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 - 1920, to Aug 11 1920, that I last saw h.e.r. alive on 8-11-12. 30 PM 1920, and that death occurred on the date stated above, at 7:10 PM.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

— (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteo Sclerosis.

— (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F B Dudley M. D.

8-13-1920 (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fulton, Missouri	19

20. UNDERTAKER	ADDRESS
C. V. Peckham	Caldwell Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1007
File No. 31448
Registered No. 11

1. PLACE OF DEATH.
County of Canyon
City of Caldwell (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah C. Frick.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Widow
6. DATE OF BIRTH. July (Month) 30 (Day) 1832 (Year)
7. AGE: 88 Yrs. 0 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work. House keeping
(b) General nature of industry, business, or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country) Maine.
10. NAME OF FATHER David Farron.
11. BIRTHPLACE OF FATHER (State or Country) Maine.
12. MAIDEN NAME OF MOTHER Cynthia Masterman
13. BIRTHPLACE OF MOTHER (State or Country) Maine
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F. E. Frick
(Address) Parma, Ida.
15. Filed Sep 10 1920 Lulu Waldron Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from July 31 1920, to Aug 2. 1920, that I last saw her alive on Aug 1 1920, and that death occured on the date stated above, at 4-15 P.M.
The CAUSE OF DEATH* was as follows:
Congestion of internal organs
Kidneys and Lungs
(Duration) ..... Yrs. ..... mos. few ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Parma Ida. M. D.
8/3 1920. (Address) Chas. B. Allen M.D.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Parma Cemetery — DATE OF BURIAL: 8-3 1920
20. UNDERTAKER: Peckham F & M Co. — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31449

Registered No. 12

Registration District No. 3

Primary Registration District No. 2007

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Parma

2. FULL NAME Baby Grace

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S

6. DATE OF BIRTH. Aug (Month) 12 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER C. S. Grace

11. BIRTHPLACE OF FATHER (State or Country) Mo.

12. MAIDEN NAME OF MOTHER Janie Gleghorn

13. BIRTHPLACE OF MOTHER (State or Country) Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C S Grace
(Address) Parma Idaho

15. Filed Sep 10 1920 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1920, to Aug 12 1920, that I last saw her alive on Aug 12 1920, and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Premature birth (6 mos.)

(Duration) ..... Yrs. ..... mos. 1/2 hrs. ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Chas. B. Allen M. D.

8/11 1920 (Address) Parma

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~: Roswell — DATE OF BURIAL: Aug 13 1920

20. UNDERTAKER: Peterson Fur Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2007
File No. 31450
Registered No. 13

1. PLACE OF DEATH
County of Owyhee
City of Homedale
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Aldine Mopkins

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1873 (Year)

7. AGE: 7 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thos B Mopkins

11. BIRTHPLACE OF FATHER (State or Country): Lane Co Oregon

12. MAIDEN NAME OF MOTHER: Laura Maud Sevey

13. BIRTHPLACE OF MOTHER (State or Country): Malheur Co. Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs G W Kershner
(Address) Homedale Idaho

15. Filed Sep 10 1920 Lulu Waldrop Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 22 1920 to Sept 4 1920
that I last saw h.im alive on Sept 4 1920
and that death occurred on the date stated above, at 4.40 M.
The CAUSE OF DEATH* was as follows:
Acute Nephritis

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Diphtheria
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) Simeon Hobbes M. D.
9/13 1920 (Address) Homedale Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ontario — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: E. V. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 31451
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. 3d & 17th N St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louise Heil

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	

6. DATE OF BIRTH Dec (Month) ..... 1919 (Year)

7. AGE 1 Yrs. 6 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER A. Heil

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Jennie Kimball

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. Heil

(Address) Nampa Ida

15. Filed Aug. 31 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1920 to Aug 28 1920 that I last saw h..... alive on ..... 19..... and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

..... (Duration) ..... Yrs. ..... mos. dead on arrival ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. O. Rose M. D.

Aug 31 1920 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlerlawn	8—6—1920
20. UNDERTAKER	**ADDRESS**
—	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2506
File No. 31452
Registered No.

1. PLACE OF DEATH
County of Canyon
City of ~~No~~
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur T Akichika
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Japanese
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: July (Month) 10 (Day) 1917 (Year)

7. AGE: 3 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: V
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: S. Akichika

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): S. Akichika

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H Fujii
(Address) Nampa Ida R 4

15. Filed Aug. 26 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1920, to Aug 26 1920
that I last saw him alive on Aug 26 1920
and that death occurred on the date stated above, at 11:20 P. M.
The CAUSE OF DEATH* was as follows:
Acute entero Colitis

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J P Murray M. D.
8/27 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 8-29 1920

20. UNDERTAKER: H Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Murray

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31454

Registered No. 15

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 11

Primary Registration District No. 2048

County of Lincoln

City of Dade Springs Idah (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph L. Barnett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
M	W	

6. DATE OF BIRTH: June (Month) 3 (Day) 1898 (Year)

7. AGE: 22 yrs. 0 mos. 28 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Rancher

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Ephiem Barnett

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Elyabeth Ellen Perkins

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ellis Karl Loy
(Address) Dade Springs Idah

15. Filed June 4 1920 Ellis Karl Loy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 26 1920, to June 1 1920 that I last saw h- alive on June 1, 1920 and that death occurred on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:

Concussion Brain

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) Chronic Nephritis

..... (Duration) 1 yrs. — mos. — ds.

(Signed) Ellis Karl Loy M. D.

July 6 1920 (Address) Dade Springs Idah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: June 4, 1920

20. UNDERTAKER: Woodland & Johnson — ADDRESS: Malad Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13 Please return immediately

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31455
Registered No. 426

1. PLACE OF DEATH.
County of Cassia
City of Burley
(If death occurs away from usual residence, give facts called for under special information.)

Registration District No. 117
Primary Registration District No. 2196
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josephosa Rosalia Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April 4. 1911 (Month) (Day) (Year)

7. AGE: 9 Yrs. 4 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George R. Jones.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Mary M. Chadwick.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Geo. R. Jones.
(Address) Standrod Ida.

15. Filed Aug. 23 1920
Dr. J. E. Patterson
Burley, Ida.
Local Registrar

SYMS - YORK OP., PTRS. & ROBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15 1920, to Aug. 22 1920, that I last saw her alive on Aug. 22 1920 and that death occured on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:
Peritonitis following
Ruptured appendix
Operation Aug. 20-1920.
(Duration) Yrs. mos. 9 days.

Contributory (Secondary)
(Duration yrs. mos. ds.

(Signed) J. E. Patterson M. D.
8-23 1920 (Address) Burley, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Standrod Ida. DATE OF BURIAL: 8/24/1920.

20. UNDERTAKER: [illegible] ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

3145 6

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3145
Registered No. 4794

Registration District No. 117
Primary Registration District No. 2196

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Andrew Tracy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 18 (Day) 1890 (Year)

7. AGE: 30 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: David Samuel Tracy

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Harriet Rebecca Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D S Tracy
(Address) York Utah

15. Filed Aug. 25 1920 Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-22-1920 to 8-24-1920 that I last saw him alive on 8-24-1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Wounds from
Circular Saw in
Saw Mill
(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)
— (Duration) — Yrs. — mos.

(Signed) Joseph Fremstad M. D.
19... (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: York — Utah
DATE OF BURIAL: Aug 1920

20. UNDERTAKER: Rivervalt
ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31457

Registered No. 445

1. PLACE OF DEATH.

County of Cassia

City of Burley.

Registration District No. 117

Primary Registration District No. 2146

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Manning Munson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug. (Month) 6. (Day) 1920. (Year)

7. AGE: .....Yrs. .....Mos. 5 ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Athome.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Roy Munson.

11. BIRTHPLACE OF FATHER (State or Country): Okla.

12. MAIDEN NAME OF MOTHER: Reva Manning.

13. BIRTHPLACE OF MOTHER (State or Country): Okla.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Roy M

(Address) Burley Ida.

15. Filed Aug. 9th 1920 J. C. Pattison Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 11 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 6 1920, to Aug. 11 1920, that I last saw him alive on Aug. 1 1920, and that death occured on the date stated above, at 10:15 A. M.

The CAUSE OF DEATH* was as follows:

Nephritis Disease

.....(Duration) .....Yrs. .....mos. 2 ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J. C. Pattison M. D.

8-11 1924 (Address) Burley, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Aug 12 1920

20. UNDERTAKER: L. D. Gallogly. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31458
Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of .....
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ..... St.)

2. FULL NAME Laverna Tilley Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 15 (Day) 1911 (Year)

7. AGE: 7 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: A C Tilley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ethel Robertson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A C Tilley
(Address) Burley

15.
Filed Aug 20 1920
Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 1920 to Aug 20 1920
that I last saw her alive on Aug 20 1920
and that death occurred on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Diphtheria

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory .....
(Secondary)

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) J. N. Cullen M. D.

.....19.... (Address) Burley

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant Hill Cemetery — DATE OF BURIAL: Aug 21. 1920

20. UNDERTAKER: Rice Watt — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

31459

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2196
File No.
Registered No. 430

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Conover

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Married

6. DATE OF BIRTH. Dec 23 1874
(Month) (Day) (Year)

7. AGE 45 Yrs. 8 Mos. 7 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Peter Conover

11. BIRTHPLACE OF FATHER (State or Country) Ky

12. MAIDEN NAME OF MOTHER Jane McCord

13. BIRTHPLACE OF MOTHER (State or Country) La

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R Conover
(Address) Burley Ida

15. Filed 9-1-20 1920 W. J. Pattison
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 30 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 26 1920 to Aug. 30 1920
that I last saw him alive on Aug. 30 1920.
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. E. Pattison M. D.
9-1 1920. (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery — DATE OF BURIAL Sept. 1 1920.

20. UNDERTAKER Kinnatt — ADDRESS Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

Patterson.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31460

Registered No. 421

Registration District No. 117

Primary Registration District No. 2

1. PLACE OF DEATH.

County of Cassia

City of Burley

(No. Burley Box 335 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Richins.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. 26. 1920.
(Month) (Day) (Year)

7. AGE: ... Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Jesse Willmott Richins

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Alice Jackson.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jesse W. Richins
(Address) Burley. Idaho.

15. Filed Aug. 2 1920 J. J. Patterson
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. 1 1st 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 26 1920, to Aug. 1st 1920, that I last saw him alive on July 28 1920, and that death occured on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Whooping Cough.

(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Malnutrition

(Duration yrs. 5 mos. ds.
(Signed) J. C. Patterson M. D.
8-2 1920 (Address) Burley. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Aug. 2. 1920.

20. UNDERTAKER: L. B. Tolley. ADDRESS: Burley. Ida.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 117
Primary Registration District No. 2196
File No. 31461
Registered No. 448

County of
City of
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John L. Dunlevie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 18th (Day) 1883 (Year)

7. AGE: 37 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Patrick Dunlevie

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Bridget Connely

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bridget J. Whidden
(Address) Hyplains, Ida.

15. Filed 9-2 1920 — Dr. J. C. Patterson, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 25 1920 to Sept 1 1920
that I last saw h... alive on Sept 1 1920,
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Pleuritis following
ruptured appendix
was dead when I arrived
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. C. Patterson M. D.
9-2 1920 (Address) Bonners, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wash. DATE OF BURIAL: 9-4 1920

20. UNDERTAKER: L. B. Dalbey ADDRESS: Bonners, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 31462
Registered No. 449

1. PLACE OF DEATH
County of Cassia
City of Burley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Lee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 4th (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ½ hr. ds.
IF LESS than 1 day how many ½ hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. Bailey Lee

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Irene Teasdale

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Bailey Lee
(Address) Burley Idaho

15. Filed Sept. 4th 1920 Dr. J. C. Patterson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 4th 1920 to Sept. 4th 1920 that I last saw he alive on Sept. 4 1920 and that death occurred on the date stated above, at 1:00 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth

.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
9-5 1920 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Idaho — DATE OF BURIAL: 9-4-1920

20. UNDERTAKER: None — ADDRESS: .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 119

Primary Registration District No.

File No. 31463

County of Cassia

City of Albion (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A. Bridger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October (Month) 24 (Day) 1847 (Year)

7. AGE: 72 Yrs. 9 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock Farmer.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Josiah Bridger.

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Margaret Stu[illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. J. A. Bridger.
(Address) Albion Ida.

15. Filed Sept 8 192[illegible] C. I. Eaton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1920, to July 26 1920, that I last saw him alive on July 23 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia & general debility

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. I. Eaton M. D.
9/8 192[illegible] (Address) Malta Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Ida — DATE OF BURIAL: July 27 192[illegible]

20. UNDERTAKER: L. B. Talboys — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31465
Registered No. 41

1. PLACE OF DEATH.
County of Clearwater
City of Orofino,
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 40
Primary Registration District No. 2168

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. J. L. Puryear,

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
About X (Month) 1 (Day) 853 (Year)

7. AGE
About yrs. 67 Years mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer) ..... Housework

9. BIRTHPLACE (State or Country) United States

10. NAME OF FATHER ? Able Wright

11. BIRTHPLACE OF FATHER (State or Country) ? Kentucky

12. MAIDEN NAME OF MOTHER ? Martha Sparling

13. BIRTHPLACE OF MOTHER (State or Country) ? [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Givens
(Address) Orofino, Idaho.

15. Filed Aug 25 1920 J. M. Family Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
August X (Month) 24th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 14th 1920 to Aug. 24th 1920 that I last saw h er alive on Aug 24th 1920 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Mania

(Duration) ? yrs. ? mos. ? ds.

Contributory (Secondary) Insanity

(Duration) ? yrs. ? mos. ? ds.

(Signed) John Givens M. D.
Aug 25 1920. (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 10 mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Lewiston, Idaho

19. PLACE OF BURIAL OR REMOVAL Grangeville Ida. | DATE OF BURIAL ..... 191..

20. UNDERTAKER C. E. Bolt Mortuary Svcs | ADDRESS Orofino Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31466
Registered No. 42

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168

2. FULL NAME Thomas Lewis Harris
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: Oct 2 (Month) 1853 (Day) (Year)

7. AGE: 67 Yrs. 10 Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: William Harris

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William McKinley Harris
(Address) Orofino

15. Filed Aug 28 1920 J. M. Stanley Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1920 to Aug 27 1920 that I last saw h alive on Aug 27 1920 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows: Shock following being run over by a 2½ ton truck.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earl J. Horswell M. D.
Aug 27 1920 (Address) Orofino Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grange Mont Ida — DATE OF BURIAL: Aug 29 1920

20. UNDERTAKER: Bell and Sons — ADDRESS: Orofino Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 2168
File No. 31467
Registered No. 43

1. PLACE OF DEATH.
County of Latah
City of Moscow (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe Bailey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1853 (Year)

7. AGE about 67 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Pennsylvania

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER
(State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER
(State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Pitteberry
(Address) Moscow Idaho

15.
Filed Sept 1 1920 J. M. Purdy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
August 31 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 22 1920, to Aug 31 1920
that I last saw him alive on Aug 31 1920
and that death occurred on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

? ? ?
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Insanity
(Duration) about 30 yrs. ..... mos. ..... ds.

(Signed) J. Kennedy Givens M. D.
8/31/1920 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 10 yrs. 6 mos. 9 days. In the State ? yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? ?
Former or usual residence Shoshone Co., Ida.

19. PLACE OF BURIAL OR REMOVAL: Sanitarium Cemetery
DATE OF BURIAL: Sept 2 1920

20. UNDERTAKER: P. M. Johnson
ADDRESS: Moscow Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Clark

City of Dubois

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 125

Primary Registration District No. 2203

(No. ....., ... St.)

File No. 31468

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Kathleen Madden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: 8 (Month) 1 (Day) ..... (Year)

7. AGE: 1 yrs. 7 mos. 8 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jerry Thomas Madden

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Edna Mae Pattee

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jerry J. Madden
(Address) Dubois

15. Filed Aug 25 1920 CE Jones MD
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/17 1920, to 8/16 1920, that I last saw her alive on Aug 16th 1920, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery -

(Duration) 1 yrs. ..... mos. 5 ds.

Contributory (Secondary) Something indigestable eaten

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A Howard Young M. D.

8/26 1920 (Address) Dubois, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho

DATE OF BURIAL: 8/17 1920

20. UNDERTAKER: Home

ADDRESS

SYMS - YORK CO., PTRS. & DORS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 2153
File No. 31469
Registered No.

1. PLACE OF DEATH
County of Lincoln
City of Darlington
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henrietta Bell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 30 (Day) 1910 (Year)

7. AGE: 10 Yrs. ..... Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Star Idaho

10. NAME OF FATHER: Alexander W. Bell

11. BIRTHPLACE OF FATHER (State or Country): Ia.

12. MAIDEN NAME OF MOTHER: Maud. P. Cleek

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. W. Bell.
(Address) Darlington Idaho

15. Filed Sept 17 1920 Rose Mawer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 7 1920, to July 9 1920
that I last saw h.r alive on July 9 1920
and that death occurred on the date stated above, at 1150 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis (appendicitis)

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. H. Farrell M. D.

7/9 1920 (Address) Mackay Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
File No. 31476
Registered No.

1. PLACE OF DEATH
County of Custer.
City of White Knob.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jas. M. Allen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Joe Allen.

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Howard D. Stafford
(Address) Mackay-Ida.

15. Filed Sept 17 1920 Roy Nowocki
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 12a M.
The CAUSE OF DEATH* was as follows:
Accidental.
(Fracture of Skull)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) W. H. Farrell M. D.
9/13 1920 (Address) Mackay Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 35
Primary Registration District No. 2021
File No. 31472
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Hammett
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy William Rouse
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: Sept (Month) 3 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER C A Rouse

11. BIRTHPLACE OF FATHER (State or Country) Mich

12. MAIDEN NAME OF MOTHER Mary M Laughlin

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C A Rouse
(Address) Hammett Ida

15. Filed September 10 1920 J. W. Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from September 3 1920, to September 9 1920, that I last saw him alive on September 3 1920, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:
Transition - Congenital and delayed delivery of after coming breech from foot delivery
(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.
Sept 10 1920 (Address) Glenns Ferry Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Glenns Ferry Idaho	Sept 12 1920

20. UNDERTAKER J W Chubbuck #185 ADDRESS Glenns Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19. ITEM #12 MOTHER'S MAIDEN NAME AMENDED 12-16-2009 CMW

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Franklin
City of Fairview
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2119
(No. ..... St.)

File No. 31473
Registered No. 63
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nedra Egbert

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug. (Month) 28 (Day) 1912 (Year)

7. AGE: Yrs. ..... Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Herald Egbert

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: LULU WADDOUPS ~~Nadda Waddoups~~

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Herald Egbert
(Address) Fairview

15. Filed Sept 13 1920 D.C. Rutter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1920, to Sept 3 1920, that I last saw her alive on Sept 2 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Acute Gastritis
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Premature 6 & no.
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. P. Cutler M. D.
19..... (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fairview — DATE OF BURIAL: 9/7 1920

20. UNDERTAKER: G.A. Lundgren — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

DEC 14 2009

IDAHO DEPARTMENT OF HEALTH AND WELFARE
BUREAU OF HEALTH POLICY AND VITAL STATISTICS
AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of Idaho
County of Franklin } SS

Certificate No. 1920-31473

Date Filed 09/13/1920

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth, Death, Marriage, etc.)

for Nedra Egbert (Name on Original Certificate) who died (Was Born, Died, etc.) on 09/03/1920 (Date of Event)

in Fairview (Franklin Co), Id. (Place of Event)

are erroneous or were omitted.

ITEMS TO BE CORRECTED	FROM	TO
12 mother's maiden name	Luella Waddrup	Lulu Waddoups

Subscribed and sworn to before me this 11th day of December, 2009

Notary Public, CAROL O HODGES

Residing at PRESTON, ID

My commission expires 01-20-2011 (Seal)

Carol O. Hodges

Herald C Egbert
Signature of Applicant

470 So 4th South Preston Id. 83263
Street Address, City, State and Zip

CAROL O HODGES NOTARY PUBLIC STATE OF IDAHO

SUPPORTING AFFIDAVIT OF A SECOND PERSON

(Must be completed ☐) _____

(Is not necessary ☒) _____

State of _____
County of _____ } SS

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____

Notary Public, _____

Residing at _____

My commission expires _____ (Seal)

_____
Signature of Applicant

_____
Street Address, City, State and Zip

December 4, 2009 UTAH APPLICATION FOR LICENSE TO MARRY APPLICATION #33769
HERALD JOS. EGBERT & LULU WADDOUPS SWORN TO DEPUTY CLERK
1-13-1920 VIEWED BY VS
UTAH BIRTH CERTIFICATE #27-03-800 HERALD CLAIR EGBERT BORN
12-22-1927 MOTHER'S MAIDEN NAME: LULU WADDOUPS AMENDED
3-7-1990 VIEWED BY VS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31474

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 41
Registered No.

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Myrtle Sturi

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 31 (Day) 1918 (Year)

7. AGE: 2 Yrs. 0 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Gottfred Sturi

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Martha Schary

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Alfred Sturi
(Address): Preston Idaho

15. Filed Sept 13 1920 Dr A R Cutler Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1920 to Aug 29 1920 that I last saw h.r alive on Aug 29 1920, and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos 2 days.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Dr A R Cutler M. D.

Aug 31 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: 8/31 1920

20. UNDERTAKER: G B Lundquist — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Curtis Jr.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 31475
Registered No. 60

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME LeRoy George Spackman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	W	Single

6. DATE OF BIRTH: June (Month) 30 (Day) 1915 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Preston

10. NAME OF FATHER L. A. Spackman

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Mrs Julia Jensen

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. A. Spackman
(Address) Preston

15. Filed Sept. 13 1920. Dr. A. R. Curtis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1920 to Aug 27 1920 that I last saw h[illegible] alive on Aug 27 1920 and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:
Surgical shock. Hrs

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Hemo Asthenia
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. R. Curtis M. D.
19 ..... (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	Aug 30 1920

20. UNDERTAKER G. A. Lundgren ADDRESS Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31476

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
(No. ..... St.)

File No. 62
Registered No. .....

1. PLACE OF DEATH
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Weaver Harrington
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May 6 (Month) (Day) 1844 (Year)

7. AGE: 76 Yrs. 3 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Conn.

10. NAME OF FATHER: Virginia Harrington

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Phoebe Weaver

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emer Porter
(Address) Preston Idaho

15. Filed Sept 13 1920
D. E. K. Curtis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 1 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 28 1920, to Aug 16 1920, that I last saw h.i.M. alive on Aug 16 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Senility — Had a severe type of arterio-sclerosis that had existed for many years
(Duration) Yrs. 9 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis D Hand M. D.
9/3 1920 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Preston

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: 9/3 1920

20. UNDERTAKER: G. A. Landquist
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 219
File No. 31477
Registered No. 59

1. PLACE OF DEATH
County of Franklin
City of Preston (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James H Bosworth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 8 (Day) 1862 (Year)

7. AGE: 58 Yrs. 7 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Enterprise Utah

10. NAME OF FATHER: James L Bosworth

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Henrietta Hales

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennett L Bosworth
(Address) Preston Idaho

15. Filed Sept 13 1921 D A Rutter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1920 to Aug 10 1920
that I last saw h..... alive on Aug 7 1920
and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Hemiplegia
.....
.....
(Duration) ..... Yrs. 3 mos. ..... ds.
Contributory (Secondary) Sarcoma of right kidney
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. D. Rutter M. D.
19..... (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston Ida. DATE OF BURIAL: Aug 12 1920

20. UNDERTAKER: L A Lundquist ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 31478
Registered No. .....

1. PLACE OF DEATH

County of Fremont
City of St Anthony

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ceal Leathan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 13 (Day) 1916 (Year)

7. AGE: 4 Yrs. 2 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ——— ———
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Roft River, Idaho.

10. NAME OF FATHER: Robert L. Leathan

11. BIRTHPLACE OF FATHER (State or Country): Wellsville, Utah.

12. MAIDEN NAME OF MOTHER: Ira George

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert E Leatham
(Address) St Anthony Ida

15. Filed Sept 10 1920 W B Wix
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 11th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11th 1920 to Aug 11th 1920 that I last saw him alive on Aug 11th 1920. and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Dysentery

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J Frank Hathaway M. D.
Aug 13th 1920 (Address) St Anthony Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19.....
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31479

Registered No. .....

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

County of .....

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ella Bonneau

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 13 (Day) 1894 (Year)

7. AGE: 26 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: August Jacobson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Edward Bonneau

(Address) Ashton Idaho

15. Filed 8/28 1920 A. Mooreman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1920, to Aug 27 1920, that I last saw her alive on Aug 27 1920, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows: Chronic Bright's Disease.

(Duration) Last Year mos. ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E. F. Hayes M. D.

Aug 28 1920 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pine View Cemetery Ashton — DATE OF BURIAL: Aug 29 1920

20. UNDERTAKER: Lewis Kerr — ADDRESS: Ashton Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BOKS. 24654

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31480
Registered No. .....

1. PLACE OF DEATH.
County of .....
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

2. FULL NAME Reva Elizabeth Hanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 2 (Day) 1920 (Year)

7. AGE: 1 Yrs. 3 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER C E Hanson

11. BIRTHPLACE OF FATHER (State or Country) Huntington Utah

12. MAIDEN NAME OF MOTHER Lottie Draluniger

13. BIRTHPLACE OF MOTHER (State or Country) Huntington Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Lottie Hanson
(Address) Ashton Idaho

15. Filed 8/10 1920 A M Meservey
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 8 (Month) — 9 (Day) — 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Did not see deceased 191..., that I last saw h... alive on the 9th day of Aug 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Died Suddenly
Possibly Hiss-Colitis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pertussis
(Duration) — yrs. — mos. — ds.

(Signed) C A Meservey M. D.
8/10 1920 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days
In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pine View Cemetery Ashton
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: Lemmon Risen
ADDRESS: Ashton Idaho

FORM V. S. No. 5-25 M. 1-16-13 Please return immediately

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31481
Registered No. .....

1. PLACE OF DEATH.
County of .....
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carrie Matilda Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE 59 Yrs. ..... Mos. 11 ds. 18
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER John Larsen

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Philip Moore
(Address) Ashton Idaho

15. Filed 9/1 V 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1920, to Aug 31 1920, that I last saw h[illegible] alive on Aug 31 1920, and that death occured on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Acute Pneumonia

(Duration) About 7 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Constipation Intestinal Intoxication produced

(Duration) 0 Yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
Sept 1920 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ashton Idaho
DATE OF BURIAL Sept 3 1920

20. UNDERTAKER [illegible]
ADDRESS Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31482
Registered No. .....

1. PLACE OF DEATH.
County of .....
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME Mrs Dinian Marshall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. January (Month) 29 (Day) 1894 (Year)
7. AGE: 26 Yrs. 7 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Glendale Idaho
10. NAME OF FATHER: Francis M. Crouch
11. BIRTHPLACE OF FATHER (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Mary Wheeler
13. BIRTHPLACE OF MOTHER (State or Country): Virginia
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Marshall
(Address) Ashton Idaho
15. Filed 9/7/1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from August 28 1920, to Sept 6 1920, that I last saw h[illegible] alive on Sept 6 1920, and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
Inflamatory Rheumatism
..... (Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Bulbar Spy. Paralysis, Chied
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E. L. Hargis M. D.
9/6 1920 (Address) Ashton Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho — DATE OF BURIAL: 9-10 1920
20. UNDERTAKER: [illegible] — ADDRESS: Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SVMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 2020
File No. 31483
Registered No. ____

1. PLACE OF DEATH
County of Gem
City of Sweet
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Miller Marguerite Montgomery
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: July (Month) 9 (Day) 1904 (Year)

7. AGE: 16 Yrs. 1 Mos. 11 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: student
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: C.C. Montgomery

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Anna Critchfield

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Forest E. Robb
(Address) Smiths Ferry Ida

15.
Filed 8/21 1920
J.L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1920 to Aug 6 1920 that I last saw h-- alive on Aug 6 1920 and that death occurred on the date stated above, at [redacted] A.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ____ Yrs. ____ mos. 14 ds.

Contributory (Secondary) acute Rheumatic Fever

(Duration) ____ yrs. 1 mos. ____ ds.

(Signed) A. G. Byrd M. D.

8/21 1920 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sweet Idaho	8/21 1920
20. UNDERTAKER: C.D. Buckman	ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31484

Registered No.

1. PLACE OF DEATH

County of Gem

City of Emmett

(No. ..... St.)

Registration District No. .....

Primary Registration District No. 90 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Gardner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	married

6. DATE OF BIRTH: Feb (Month) 8 (Day) 1838 (Year)

7. AGE: 82 Yrs. 6 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: McCullough

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James A. Gaynard

(Address) Emmett Idaho

15.

Filed 8/21 1920

J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1909, to Aug 20 1920 that I last saw h[illegible] alive on Aug 20 1920, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Uraemia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary): Epilepsy

(Duration) 20 yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.

8/21 1920 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	8/22 1920

20. UNDERTAKER	ADDRESS
C. D. Bucknum	Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31485

1. PLACE OF DEATH.
County of Gem
City of Sweet
(No. ....., ... St.)

Registration District No. 9
Primary Registration District No. 2021

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pauline Mildred Kendall

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Single

6. DATE OF BIRTH: Dec 21 1915
(Month) (Day) (Year)

7. AGE: 4 yrs. 7 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joyce Kendall.

11. BIRTHPLACE OF FATHER (State or Country): Tennessee.

12. MAIDEN NAME OF MOTHER: Mildred Ulmer

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joyce Kendall
(Address) Sweet - Idaho.

15.
Filed 8/25 1920 J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 5 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 5 1920, to Aug. 5 1920 that I last saw her alive on Aug. 5 1920 and that death occurred on the date stated above, at 2:50 P. M.

The CAUSE OF DEATH* was as follows:

Burns of Body and Extremities (Accidental)

(Duration) Four Hours

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Austin E. Byrd M. D.

Aug 6 1920 (Address) Emmett, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem
DATE OF BURIAL: Aug 7 1920

20. UNDERTAKER: Summers & Cobb
ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2020
Primary Registration District No.
File No. 31486
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernestine Christensen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem
4. COLOR OR RACE: wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widowed

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1839 (Year)

7. AGE: 81 Yrs. 7 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Carl Schiller

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Ludwig
(Address) Emmett Ida

15. Filed 8/29 1920 J. A. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1920, to Aug 26 1920, that I last saw her alive on Aug 26 1920, and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Burton A Clark M. D.
19 (Address) Emmett Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida — DATE OF BURIAL: 8/28 1920
20. UNDERTAKER: O. D. Bucknum — ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31487
Registered No.

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 1014
(No. , St.)

2. FULL NAME George J Sturm

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: August 27 1849 (Month) (Day) (Year)
7. AGE: 70 yrs. 11 mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession, or particular kind of work: Merchant
(b) General nature of industry business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER:
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER:
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Stella A Sturm
(Address) Colorado Springs Colo
15.
Filed 8-17 1920 H Ham Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 11 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...
that I last saw h... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Was found dead in bed and in all probability died of rheumatism of heart
(Duration) ... yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) H E Lamb M. D.
Aug 14 1920 (Address) Gooding Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... ds. In the State ... yrs ... mos ... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Denver Colo
DATE OF BURIAL: 8-19 1920
20. UNDERTAKER: A E Thompson
ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31488

1. PLACE OF DEATH. Registration District No.
County of Gooding Primary Registration District No.
City of Bliss (No. , St.) Registered No.
If death occurs away from usual residence, give facts called for under special information. If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Joseph David Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Married.

6. DATE OF BIRTH: June (Month) 9 (Day) 1854 (Year)

7. AGE: 66 yrs. mos. 15 ds. IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work: Rancher —
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: George N. Baker

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Baker
(Address) Bliss, Idaho

15. Filed 8 17 1911 W. H. Hay Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 19 1920 to June 23 1920 that I last saw h[illegible] alive on June 23 1920, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Injury by being hit on head by derrick boom, causing injury at base of brain.
(Duration) 5 yrs. mos. 5 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. E. Lamb M. D.
June 24 1920 (Address) Gooding

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Gooding Ida. DATE OF BURIAL: 6 26 1920

20. UNDERTAKER: A. E. Thompson ADDRESS: Gooding Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2014
Primary Registration District No.
File No. 31489
Registered No.

1. PLACE OF DEATH.
County of Gooding
City of Gooding
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lydia Bowers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single —
6. DATE OF BIRTH. Nov. (Month) 15th (Day) 1899 (Year)
7. AGE: 20 Yrs. 9 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: General Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Colorado —
10. NAME OF FATHER: Henry Bowers —
11. BIRTHPLACE OF FATHER (State or Country): Germany —
12. MAIDEN NAME OF MOTHER: Anna Zobler —
13. BIRTHPLACE OF MOTHER (State or Country): Switzerland —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Bowers
(Address) Tuttle, Idaho —
15. Filed 8/28/20 191 — F D Carpenter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 28th (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from August 25— 1920, to August 28 1920, that I last saw h. alive on August 28 1920, and that death occured on the date stated above, at 9A M.
The CAUSE OF DEATH* was as follows:
Peritonitis following
Rupture of Appendix —
(Duration) Yrs. mos. ds.
Contributory (Secondary) (Duration) yrs. mos. ds.
(Signed) L W Carey — M. D.
8/28 1920 (Address) Gooding, Idaho —

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos. 2½ days In the State 17 yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence Tuttle, Idaho —

19. PLACE OF BURIAL OR REMOVAL: Gooding, Idaho — DATE OF BURIAL: 8-30 1920
20. UNDERTAKER: A E Thompson — ADDRESS: Gooding, Idaho

BYMS - YORK CO., PTRS. & BOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

31492

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

File No. 22
Registered No. .....

1. PLACE OF DEATH.

County of Idaho
City of Kenterville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Johann Peter Sonnen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Nov (Month) 25 (Day) 1833 (Year)

7. AGE: 86 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Fluggerinze
(Address) Kenterville Idaho

15.
Filed Aug 4th 1920. H Bollacker
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jany 9 1920, to August 4 1920, that I last saw him alive on August 4 1920, and that death occured on the date stated above, at 11 55 M.

The CAUSE OF DEATH* was as follows:
Senile Gangrene

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H Bollacker M. D.
8/4 1920. (Address) Cottonwood Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kenterville Ida
DATE OF BURIAL: Aug 5 1920

20. UNDERTAKER: A H Nare
ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24853

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

31493

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 23
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Idaho
City of Greencreek
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 105
Primary Registration District No. 2183
(No. ..... St.)

2. FULL NAME Elisabeth Rengali

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widow

6. DATE OF BIRTH. May (Month) 27 (Day) 1851 (Year)

7. AGE 69 Yrs. 2 Mos. 10 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Switzerland

10. NAME OF FATHER Not known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Rengali
(Address) Cottonwood Idaho R. 1

15. Filed Aug 7 1920. H B Baker Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 28 1920 to Aug 6 1920 that I last saw h.. alive on Aug 5 1920 and that death occurred on the date stated above, at 4.45 P. M.

The CAUSE OF DEATH* was as follows:
Paralysis
.....
.....
.....(Duration) .... Yrs, ... mos. 3 ds.
Contributory (Secondary) Chronic Valvular Heart disease
.....(Duration) 1 Yrs. .... mos. .... ds.
(Signed) J. D. Shumate M. D.
8/6 1920 (Address) Cottonwood Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Greencreek Ida | DATE OF BURIAL 8-7 1920

20. UNDERTAKER A H Nau | ADDRESS Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

31494

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 105

Primary Registration District No. 2183

File No. 24

County of Idaho

City of Ferdinand (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frances Jane Womack ~~Womack~~

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH

Nov (Month) 28 (Day) 1918 (Year)

7. AGE

1 yrs. 8 mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Henry Womack

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Victoria Goodall

13. BIRTHPLACE OF MOTHER (State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard J Beazley

(Address) Ferdinand Idaho

15.

Filed Aug 12 1920 H Blair Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 1920, to Aug 12 1920 that I last saw h[illegible] alive on Aug 12 1920 and that death occurred on the date stated above, at 2 A M.

The CAUSE OF DEATH* was as follows:

Pneumonia - Croupous.

(Duration) ..... yrs. ..... mos. 12 hrs. ..... ds.

Contributory (Secondary) Acute Enteritis with

(Duration) ..... yrs. ..... mos. 1 ..... ds.

(Signed) J A Slaminick M. D.

Aug 12 1920 (Address) Coldwood Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ilo Idaho — DATE OF BURIAL: Aug 12 1920

20. UNDERTAKER: Dick Adkisson — ADDRESS: Ferdinand

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

died 19

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

31495

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 25
Registered No.

1. PLACE OF DEATH.
County of Idaho Co
City of Ferdinand

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Garden Moser

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 3 (Month) 12 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Baby
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Co. Ferdinand

10. NAME OF FATHER: Robert E. Moser

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Florence M. Brown

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. E. Moser
(Address) Ferdinand Idaho

15. Filed Aug 14 1920 W. B. Blake Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
..... 191....
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191...., to ..... 191....
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

.....

.....

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191....

20. UNDERTAKER: Albert Hoff | ADDRESS: Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

31496 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. .....
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Albert McElherne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Child

6. DATE OF BIRTH
Apr 14 1918
(Month) (Day) (Year)

7. AGE
2 yrs. 2 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. J. McElherne

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Maria Fernandez

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. J. McElherne
(Address) Rigby Idaho

15.
Filed 9/10 1920 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 14 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1920 to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental
Drowning
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Anderson M. D.
6/15 1920 (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby
DATE OF BURIAL: June 16 1920

20. UNDERTAKER: Friends
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

31497

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Lorenzo
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ..... St.)

File No. .....
Registered No. 26
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Ferdinand Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (*Write* the word.)
M	White	widowed

6. DATE OF BIRTH: Sept 12 (Month) (Day) 1832 (Year)

7. AGE: 87 yrs. 11 mos. ..... ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Anders Fredrickson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Johanna Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charlotta Anderson
(Address) Lorenzo

15. Filed 9/10 1920 Ray N Fiske, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug 13 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 11 1920, to Aug 13 1920, that I last saw h alive on Aug 13 1920 and that death occurred on the date stated above, at 11 M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) 3 yrs. ..... mos. 9 ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Palmer M. D.
8/14 1920 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Annis Ida — DATE OF BURIAL: Aug 15 1920

20. UNDERTAKER: Daird Young — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH 31498

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. .....
Registered No. 21
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME .....

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Infant

6. DATE OF BIRTH: June 7, 1920
(Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ira Taylor

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Hilda Thornton

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ira Taylor
(Address) Rigby

15. Filed Sept 10 1920 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: June 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to June 8 1920, that I last saw h[illegible] alive on June 8 1920 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Congenital heart-
failure & closure
of foramen ovale.

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray H Fisher M. D.
June 9 1920 (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: June 9 1920

20. UNDERTAKER: Taylor & Elerson — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

31500

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98

Primary Registration District No. 2176

File No.

County of Jefferson

City of Annis (No. ....., ... St.)

Registered No. 23

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maria Campbell Helm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widowed

6. DATE OF BIRTH June 19 1821
(Month) (Day) (Year)

7. AGE 99 yrs. 2 mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Widow
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York.

10. NAME OF FATHER John Cady.

11. BIRTHPLACE OF FATHER (State or Country) Don't Know

12. MAIDEN NAME OF MOTHER Sallie Bump.

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wallace Campbell
(Address) Lorenzo R.A.I

15. Filed Sept 10 1920 Ray H. Fisher. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Aug 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility. No Physician

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray H. Fisher. M. D.

Aug 25 1920 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Lincoln Butte Cem. Rigby. Idaho. DATE OF BURIAL Aug 26th 1920

20. UNDERTAKER Young ADDRESS Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. .....

Primary Registration District No. .....

File No. 31501

County of .....

City of .....

(No. ....., ... St.)

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Rosenlund.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. 15th 1894
(Month) (Day) (Year)

7. AGE: 25 Yrs. 7 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Denmark.

10. NAME OF FATHER: Don't know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know.

12. MAIDEN NAME OF MOTHER: Marie Rosenlund.

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lillian Jensen.
(Address) Rigby 3, Ida.

15. Filed Aug 15th 1920 Ray H. Smith, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 13th 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1920, to Aug 13th 1920, that I last saw him alive on Aug 13th 1920, and that death occured on the date stated above, at 6.40 P.M.

The CAUSE OF DEATH* was as follows:
Traumatic Peritonitis.
Ruptured intestine from
kick by horse.
(Duration) ..... Yrs. One mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Ray H. Smith M. D.
1920 (Address) Rigby, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby, Ida. DATE OF BURIAL: Aug 15 1920

20. UNDERTAKER: Taylor & Ellerson ADDRESS: Rigby, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & STNRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Clark (No. ....., ... St.)
Registration District No. 98
Primary Registration District No. 2176
File No. 31502
Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maurice Jensen

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH
..... (Month) ..... (Day) 1890 (Year)

7. AGE
30 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Arizona

10. NAME OF FATHER: Anders Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Josephine Holes

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Walter Scholes
(Address) Rigby, Idaho

15.
Filed 9/10 1920 Ray H Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1920, to Aug 24 1920, that I last saw him alive on Aug 24 1920 and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Suicide by Shooting
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Resp failure Paralysis
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) O. F. Call M. D.
8/25 1920 (Address) Rigby, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby
DATE OF BURIAL: Aug 26 1920

20. UNDERTAKER: C. E. Sherwood
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PE[illegible]NT RECORD.
MARGIN RESERVED FOR BINDIN[illegible]

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

(90)

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23

Primary Registration District No. 1012 - 2012

File No. 31563

Registered No.

1. PLACE OF DEATH

County of Jerome

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME W. Alfred Fisher

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Sept 16 1894 (Month) (Day) (Year)

7. AGE: 25 Yrs. 10 Mos. 19 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colo

10. NAME OF FATHER: Andrew Jackson Fisher

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Mary Elizabeth Albertson

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew J. Fisher
(Address) Clatch Idaho

15. Filed 8-16 1920 E. D. Piper M. D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 5 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,
that I last saw h.... alive on ....19....,
and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:
Accidental — Due to Crushing injury over heart by lava rock, following Explosion — Coroners jury

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) H. M. Schmerstall M. D.
Aug 9 1920 (Address) Jerome Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Ida — DATE OF BURIAL: Aug 7 1920

20. UNDERTAKER: D & L Henrson — ADDRESS: Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1012-2012
File No. 31504
Registered No.

1. PLACE OF DEATH

County of Jerome
City of Jerome
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Amelia Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Sept 4 (Month) (Day) 1870 (Year)

7. AGE: 49 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnesota

10. NAME OF FATHER: Seeber

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dont Known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otto Brown
(Address) Jerome

15. Filed March 17 1920
E. E. Piper
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Mch 17 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Mar 15 1920 to Mar 17 1920
that I last saw her alive on Mar 17 1920
and that death occurred on the date stated above, at 4-30 A.M.
The CAUSE OF DEATH* was as follows:

Uraemic apoplexy

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm F. Schmerstall M. D.
Mar 17 1920 (Address) Jerome Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cemetary
DATE OF BURIAL: Mch 19 1920

20. UNDERTAKER: D. A. Stevenson
ADDRESS: Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31505
Registered No.

1. PLACE OF DEATH

Registration District No. 23
Primary Registration District No. 1017-2017

County of Jerome
City of 5 Mi . N.W. Jerome (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jonathan William Crutchfield.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1896 (Year)

7. AGE: 24 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John E Crutchfield.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Harriet Standfield

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John E Crutchfield
(Address) Jerome, Idaho

15. Filed July 29 1920 E. D. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1920, to July 27 1920, that I last saw him alive on July 27 1920 4:00 A.M and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F Schmerschall M. D.
July 28 1920 (Address) Jerome Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Ida
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: D. A. Stevenson
ADDRESS Jerome Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Jerome

City of Jerome

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23

Primary Registration District No. 1012-2017

(No. ..... St.)

File No. 31506

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Dell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH Feb 17 1863
(Month) (Day) (Year)

7. AGE 57 Yrs. 5 Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Gardener
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Philip Dell

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Elizabeth Yerkey

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Dell
(Address) Dubuque Ia.

15. Filed July 18 1920 E. D. Pifer M.D.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 17 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Coroner's jury verdict: Death was not due to violence

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno F. Schmershall M. D.
July 28 1920 (Address) Jerome Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome . Cem	July 22 1920
20. UNDERTAKER	**ADDRESS**
D.A.L'Herisson	Jerome

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31507

Registered No.

1. PLACE OF DEATH

County of Jerome

City of

(No. , St.)

Registration District No. 23

Primary Registration District No. 1017-2017

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo Marvin Claypool

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: May (Month) 2 (Day) 1919 (Year)

7. AGE: 1 Yrs. 3 Mos. 16 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W C Claypool

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Vesta Miller

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W C Claypool
(Address)

15. Filed Aug 18 1920 E. D. Piper M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:
Accidental. Run over by Automobile. Internal injuries

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm F Schmershall M. D.
Aug 18 1920 (Address) Jerome Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Jerome Ida	Aug 19 1920

20. UNDERTAKER	ADDRESS
D. A. L'Heureux	Jerome Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1012-2017
File No. 31508
Registered No.

1. PLACE OF DEATH
County of Jerome
City of Eden
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lehester Hartley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 26 1920 (Month) (Day) (Year)

7. AGE: Yrs. 2 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Jerome Co. Ida.

10. NAME OF FATHER: Grover C. Hartley

11. BIRTHPLACE OF FATHER (State or Country): Wyo.

12. MAIDEN NAME OF MOTHER: Nettie Large

13. BIRTHPLACE OF MOTHER (State or Country): Wyo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. H. Hartley
(Address)

15. Filed June 13 1920 E. D. Piper M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1920, to June 11 1920
that I last saw him alive on June 11 1920
and that death occurred on the date stated above, at 7 9 M.
The CAUSE OF DEATH* was as follows:

Marasmus

..... (Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. P. Scroggs M. D.
..... 19..... (Address) Eden, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1017–2017
File No. 31509
Registered No.

1. PLACE OF DEATH
County of Jerome
City of Jerome
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Lucile Brinegar
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Sept (Month) 12 (Day) 1919 (Year)

7. AGE: Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Bud Brinegar

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Etta Mary Rudolph

13. BIRTHPLACE OF MOTHER (State or Country): Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bud Brinegar
(Address) Jerome Ida

15. Filed Aug 23 1920
E. D. Piper M.D.
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 10:30 P.m. M.
The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis
secondary to
Acute Enteritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. F. Zeller M. D.
19..... (Address) Jerome Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Ida
DATE OF BURIAL: Aug 23 1920

20. UNDERTAKER: D. A. L'Heureux
ADDRESS: Jerome Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31510

Registered No.

Registration District No. 23

Primary Registration District No. 1017-2017

1. PLACE OF DEATH

County of Jerome

City of Jerome (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilma Lebene Doughty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 23 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W J Doughty

11. BIRTHPLACE OF FATHER (State or Country): Colo

12. MAIDEN NAME OF MOTHER: Mary Jane Buhler

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W J Doughty

(Address) Jerome

15. Filed June 4 1920 E. D. Pipes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 9:45 P M.

The CAUSE OF DEATH* was as follows:

Premature Infant

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Zeller M. D.

..... 19..... (Address) Jerome Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Jerome

DATE OF BURIAL: June 4 1920

20. UNDERTAKER: D. A. Stevenson

ADDRESS: Jerome

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31511

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

Registration District No. 126

Primary Registration District No. 2207

(No. ....., ... St.)

File No. 3

Registered No. 63

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Sutton.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Unknown
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work...

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Aug 25 1920

J. M. Fleming
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Aug 24 1920, that I last saw h— alive on Aug 24 1920, and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Shock + Hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Scholosis of Liver

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Fleming M. D.

8-25 1920 (Address) St Francis Hospital

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: C. Cassey — DATE OF BURIAL: 8-26 1920

20. UNDERTAKER: St Maries — ADDRESS: C D'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31512

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

Registration District No. 126

Primary Registration District No. 2207

(No. .... St.)

File No. 3

Registered No. 66

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Grace Haynes.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July 25 1879
(Month) (Day) (Year)

7. AGE: 41 Yrs. ..... Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Md

10. NAME OF FATHER H.O. Bingham

11. BIRTHPLACE OF FATHER (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Laura Blackwelder

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) Harrison Idaho

15. Filed 9-1 1920 Jas. Feeney
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug 19 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1920, to Aug 19 1920, that I last saw her alive on July 12 1920 and that death occured on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Broncholer Pneumonia

.....

.....

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) J.M. Feeney M. D.

8-19 1920 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Harrison — DATE OF BURIAL: 8-21 1920

20. UNDERTAKER: C. Connolly — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31513 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 124
Primary Registration District No. 2204
(No. ....., ... St.)
File No. 3
Registered No. 67

1. PLACE OF DEATH.
County of Kootenai
City of Harrison
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David K. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. 8 (Month) – 8 (Day) 1845 (Year)

7. AGE: 75 Yrs. 00 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: Smith

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Charles Glover
(Address) Harrison Ida

15. Filed 9 – 1 1925 J. H. Timmerman
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 25 (Day) 1925 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1920, to Aug 25 1925, that I last saw him alive on Aug 25 1925, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Timmerman M. D.
8-27 1925 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: ~~Harrison~~ Ida — DATE OF BURIAL: 8-26 1925

20. UNDERTAKER: C. Carrey — ADDRESS: C D Alene

P. E. Hunt – St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30 31514

Primary Registration District No. 1051.

File No.

Registered No. 833

1. PLACE OF DEATH

County of Kootenai

City of

(No. Ranch near Coeur D Alene St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David Evert Tobler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 9 (Day) 1882 (Year)

7. AGE: 37 Yrs. 7 Mos. 23 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Joseph Tobler

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Fylura Green

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. David Tobler

(Address) Coeur D Alene, Ida.

15. Filed Sept 4 1920 D D Dreenan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....

that I last saw h.... alive on ....19....,

and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Accidental Death from a fall from wagon.

(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) D D Drennan M. D.

8/2, 1921 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State 12 rs. ....mos....days

Where was disease contracted if not at place of death?

Former or usual residence Coeur d Alene Ida

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery

DATE OF BURIAL: Aug 4 1920

20. UNDERTAKER: A B Mooney

ADDRESS: Coeur d Alene Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 31515
Registered No. 832

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Abramson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
F.	W.	Widow

6. DATE OF BIRTH: 3 (Month) 11 (Day) 1840 (Year)

7. AGE: 80 Yrs. 4 Mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: — Swanson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: — — —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Coeur d Alene Ida
(Address) Mrs S. J. Carlson

15. Filed Sept 7, 1920 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 4 1920 to Aug 10 1920 that I last saw her alive on Aug 9, 1920, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

"Flu"

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. D. Drennan M. D.

8/12, 1920 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. CdAlene — DATE OF BURIAL: 8-12 1920

20. UNDERTAKER: O'Casey — ADDRESS: CdAlene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 31516
Registered No. 831

1. PLACE OF DEATH

County of Kootenai
City of Coeur d'Alene (No. 804, Garden St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margaret E Cole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 24 (Day) 1854 (Year)

7. AGE: 65 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Andrew Beverage

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Jeanette Hutton

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. J. Cole
(Address) Coeur d'Alene Ida

15. Filed Sept 4, 1920 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 17 1920 to Aug. 13 1920 that I last saw her alive on Aug. 14 1920 and that death occurred on the date stated above, at 3:10 P.M.

The CAUSE OF DEATH* was as follows:

Cancer.

Known (Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frances G. Stewart M. D.

8/17 1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. 7 mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Aug 16 1920

20. UNDERTAKER: R B Mooney — ADDRESS: Coeur d'Alene Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31517

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051-2051
File No. 1
Registered No. 17

1. PLACE OF DEATH

County of Kootenai
City of Athol
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm McKay

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	M

6. DATE OF BIRTH: Nov (Month) 15 (Day) 1848 (Year)

7. AGE: 71 Yrs. 8 Mos. ..... ds. 27
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Labor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Rosy McKay (his wife)
(Address) Athol Idaho

15. Filed 9/1 1920. Frank Nevy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-11 1920, to 8-11 1920, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Broken neck from
fall ne[ck]. in Runaway
man dead on my arrival

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle V Pound M. D.
8-11 1920 (Address) Spirit Lake Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? —
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Athol Idaho — DATE OF BURIAL: Aug 13 1920

20. UNDERTAKER: O W Storm — ADDRESS: Rathdrum Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31518

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Rathdrum

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1051.-2051

(No. Kootenai County Hospital)

File No. 1

Registered No. 18

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucien C Armstrong

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Nov (Month) 7 (Day) 1832 (Year)

7. AGE: 88 Yrs. 8 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James Armstrong

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Henrietta Norman

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Clara Bradford

(Address) E 114 3rd Ave Spokane Wn

15. Filed 9/1. 1920. Frank Wenz Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 10. 1920 to Aug. 21. 1920 that I last saw him alive on Aug. 20. 1920 and that death occurred on the date stated above, at 6:00 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Indigestion

about 10 (Duration) Yrs. ..... mos. ..... ds.

Contributory (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Wenz M. D.

8/25 1920 (Address) Rathdrum Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 11 days. In the State 4 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? unknown

Former or usual residence Idaho.

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Idaho — DATE OF BURIAL: Aug 23 1920

20. UNDERTAKER: C. W. Glenn — ADDRESS: Rathdrum Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31510

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30

Primary Registration District No. 1051-2051

File No. 1

Registered No. 19

1. PLACE OF DEATH

County of Kootenai

City of Rathdrum

(~~No.~~ Kootenai County hospital ~~St.~~)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm McAlister

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	

6. DATE OF BIRTH

..... 1.....
(Month) (Day) (Year)

7. AGE about 75 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) No relatives Known So can not full this out

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O W Storm

(Address) Rathdrum Idaho

15. Filed 9/1. 1920. Frank Wang
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Aug (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1. 1920, to Aug 24. 1920
that I last saw h.. alive on Aug 23rd 1920
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

about 1 Yrs. ..... mos. ..... ds.
(Duration)

Contributory (Secondary) Malaria

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Wang M. D.

8/30 1920 (Address) Rathdrum Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. 24 days. In the State 25 yrs. — mos. — days

Where was disease contracted if not at place of death? Idaho

Former or usual residence Idaho

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Ida — DATE OF BURIAL: Aug 27 19

20. UNDERTAKER O W Storm — ADDRESS Rathdrum Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31520
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of Spirit Lake
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Velva Patricia Denning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH. July (Month) 30th (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 35 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Spirit Lk, Kootenai Co, Idaho.

10. NAME OF FATHER Stuart K. Denning

11. BIRTHPLACE OF FATHER (State or Country) Grant Co. Oregon

12. MAIDEN NAME OF MOTHER Harriet Helen Bolger

13. BIRTHPLACE OF MOTHER (State or Country) Alcona Co, Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S. K. Denning
(Address) Spirit Lk, Idaho.

15. Filed 9/12 1920 Sam Kincaid Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 3 (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1920, to Sept 3 1920, that I last saw h[illegible] alive on Sept 2 1920, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Wasting Coryza
(Duration) — Yrs. — mos. 20 ds.
Contributory (Secondary) Pneumonia
(Duration — yrs. — mos. 2 ds.
(Signed) Earl D Bright M. D.
9-6 1920 (Address) Spirit Lake Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Grant Lake — DATE OF BURIAL 191

20. UNDERTAKER C. W. Hanna — ADDRESS Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & SORS. 24854

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 68
Primary Registration District No.
(No. ..... St.)
File No. 31521
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Juliaetta
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thankful Radcliff Dunlap

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. (Month) March (Day) 28 (Year) 1849

7. AGE: 71 Yrs. 5 Mos. 6 ds.
IF LESS than 1 day, how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Mr. Radcliff

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Thankful Radcliff

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miles Dunlap
(Address) Juliaetta Ida.

15. Filed Aug 5 1920 O. P. Pepple Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Aug (Day) 3 (Year) 1920

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1920, to Aug 3rd 1920, that I last saw her alive on Aug 3rd 1920, and that death occured on the date stated above, at 8:45 P M.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. A. Rothwell M. D.

Aug 4 1920 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Cem. DATE OF BURIAL: 8-5 1920

20. UNDERTAKER: L. C. Broncheau ADDRESS: Juliaetta

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 31522
Registered No. 114

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. County Home St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James McLaughlin
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: / / 1844 (Month) (Day) (Year)

7. AGE: 76 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Not known here

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos Mellea
(Address) Supt Latah Co Home

15. Filed 8/11 1920 W. H. Coulthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 14 1920, to Aug 10 1920
that I last saw h[illegible] alive on Aug 10 1920
and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of other bowels

(Duration) 1½ Yrs. mos. ds.
Contributory (Secondary) Kidney T.B. & Dropsy
(Duration) 2 yrs. mos. ds.

(Signed) F. H. Heineman M. D.
8/11 1920 (Address) Moscow Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 8/11 1920

20. UNDERTAKER: Glenn Price
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 31523
Registered No. 112

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet L. Kendrick
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Dec 21 1841 (Month) (Day) (Year)

7. AGE: 78 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Aaron Van Worner

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary Wallace

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Martha Kendrick
(Address): Moscow

15. Filed 8/11 1920 N.H. Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to Aug 11 1920, that I last saw h[illegible] alive on Aug 11 1920, and that death occurred on the date stated above, at 3 PM.

The CAUSE OF DEATH* was as follows:

Carcinoma of jaw

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) N.H. Carothers M. D.

8/11 1920 (Address) Moscow Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn. | DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: Allen Rice | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... St.)

File No. 31525
Registered No. 113

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margery May Monahan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: W hite
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: March 25 1920 (Month) (Day) (Year)

7. AGE: Yrs. 4 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Sylvander E. Monahan

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Lillian G. Gustafson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. E. Monahan
(Address) Moscow

15. Filed 8/6 1920 N. H. Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 25th 1920 to Aug. 5th 1920
that I last saw her alive on Aug 5 1920
and that death occurred on the date stated above, at 2 20 P.M.
The CAUSE OF DEATH* was as follows:
Tuberculous Meningitis

(Duration) ..... Yrs. ..... mos. 30 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. A. Cedar M. D.
..... 19 ..... (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 8/6 1920

20. UNDERTAKER: Neill Bros
ADDRESS: Moscow Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah.

City of Moscow.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 1011

(No. ..... St.)

File No. 31526

Registered No. 115

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Hunt.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 26 (Day) 1834 (Year)

7. AGE: 86 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Sidney Hunt.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Julia Geer.

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Thomas Hunt.

(Address) Moscow

15. Filed Aug 14 1920 W. H. Carruthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1920 to Aug 1920 that I last saw h.. alive on 8th Aug. 1920 and that death occurred on the date stated above, at 6.20 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. 6 mos. 1 ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Cadair M. D.

8/14 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 8/15 1920

20. UNDERTAKER: Glen Rice — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61
Primary Registration District No. 1011
File No. 21527
Registered No. 116

2. FULL NAME Andrew P. Mattson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1845 (Year)

7. AGE: 74 Yrs. 7 Mos. ..... ds. 18
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Not Known Here

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adrian Nelson
(Address) Moscow Idaho

15. Filed Aug 20 1920 W. H. Barthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26" 1920, to Aug. 18" 1920, that I last saw h.... alive on Aug 19" 1920, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Perforating ulcer of stomach

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Barthers M. D.
8/20 1920 (Address) Moscow, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Moscow

19. PLACE OF BURIAL OR REMOVAL: Moscow DATE OF BURIAL: 8/21 1920

20. UNDERTAKER: Neu Bros ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31528

Registered No. 117

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF ~~DEATH~~

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Creighton Jr. Guy.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: June (Month) 5 (Day) 1919 (Year)

7. AGE: 1 Yrs. 2 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Creighton C. Guy

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Rose E. Hamilton

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Creighton C. Guy

(Address) Moscow

15. Filed 8/28 1920 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 26 1920, to August 28 1920 that I last saw h.. alive on August 27th 1920, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Diarrhea and Enteritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Fortner M. D.

8/28 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 8/29 1920

20. UNDERTAKER: Glenn Mill | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 31529
Registered No.

1. PLACE OF DEATH
County of Latah
City of Troy (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Erick C Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: April (Month) 13 (Day) 1861 (Year)

7. AGE: 59 Yrs. 4 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) (Sweden) (State) Falun

10. NAME OF FATHER: Erick Johnson

11. BIRTHPLACE OF FATHER (State or Country) (Sweden) (State) Falun

12. MAIDEN NAME OF MOTHER: Carrie Knutson

13. BIRTHPLACE OF MOTHER (State or Country) (Sweden) (State) Falun

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alex Johanson
(Address) Troy

15. Filed Aug 25 1920 J E Prekerd Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug ~~24~~ (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1920 to Aug 24 1920
that I last saw him alive on Aug 24 1920,
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Acute Paralysis
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Influenza
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C K Henkle M. D.
8/25 1920 (Address) Troy Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Zion — DATE OF BURIAL: Aug 27 1920

20. UNDERTAKER: J E Prekerd — ADDRESS: Troy Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 31530
Registered No.

1. PLACE OF DEATH
County of Latah
City of Deary
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Homer Edwin Clark
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March 10 (Month) (Day) 1914 (Year)

7. AGE: 6 Yrs. Mos. 5 ds. 14
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Deary Idaho

10. NAME OF FATHER: Harry LeRoy Clark

11. BIRTHPLACE OF FATHER (State or Country): Washington State

12. MAIDEN NAME OF MOTHER: Selma Wickstrand

13. BIRTHPLACE OF MOTHER (State or Country): Deary Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Clark
(Address) Deary Idaho

15. Filed Aug 24 1920 — J E Pickerd, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 21 1920, to Aug 23 1920, that I last saw him alive on Aug 23 1920, and that death occurred on the date stated above, at 11.20 M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Fever (Meningitis)
(Duration) ..... Yrs. ..... mos. 11 ds.
Contributory (Secondary) Influenza
(Duration) — yrs. — mos. — ds.

(Signed) C K Henkle M. D.
8-24 1920 (Address) Deary Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Deary Idaho

19. PLACE OF BURIAL OR REMOVAL: Pine Crest Cemetery, Deary Ida. — DATE OF BURIAL: Aug 26 1920

20. UNDERTAKER: J E Pickerd — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 65

Primary Registration District No. 2145

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31531

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Potlatch

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Isora May Breed.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 13 (Day) 1863 (Year)

7. AGE: 55 Yrs. 1 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: E Brown

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Weaver.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Matthias W Breed

(Address) Illinois.

15. Filed Aug. 17 1920 F W Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 23 1920, to July 6- 1920, that I last saw h.. alive on July 6 1920 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) R L Clark M. D.

8/15 1920 (Address) Moscow Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Palouse wash. DATE OF BURIAL: Aug 15 1920

20. UNDERTAKER: E McIrvin ADDRESS: Palouse

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & STORS. 24854

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No. ....., ... St.)

File No. 31532
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marie Nusseo

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	single

6. DATE OF BIRTH: Aug. (Month) 30 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. one ds. 4h. IF LESS than 1 day how many 28 hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: nine
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Potlatch Ida

10. NAME OF FATHER: G Nusseo

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Marie Pozzibon

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G Nusseo
(Address) Potlatch, Idaho

15.
Filed Sept 1 1920 J W Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 1st. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1920, to Sept 1 1920
that I last saw her alive on Aug 31 1920
and that death occurred on the date stated above, at 1:30 A.M.
The CAUSE OF DEATH* was as follows:
Asthenia
Seven and one half months foetus
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Ernest Heer M. D.
..... 19..... (Address) Potlatch Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch, Idaho
DATE OF BURIAL: Sept 1 1920

20. UNDERTAKER: Parents
ADDRESS: Potlatch, Id

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31533
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Potlatch

Registration District No. 65
Primary Registration District No. 2145
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angelo Nunzio

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Potlatch Ida.

10. NAME OF FATHER: G. Nunzio

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Marie Rozzibon

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G Nunzio
(Address) Potlatch Ida

15.
Filed Sept 1 1920 J. W. Thompson Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30. 1920, to Aug 31 1920, that I last saw him alive on Aug 31. 1920 and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Prem Premature Birth 7½ Mth
Asthenia
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) one of Twins.
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest J Nunz M. D.
19 ..... (Address) Potlatch Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch, Idaho
DATE OF BURIAL: Sept. 1 1920

20. UNDERTAKER: Parents
ADDRESS: Potlatch, Id

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31534
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lemhi,
City of Salmon,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

2. FULL NAME Naomi Sandrus Manfull

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 20 (Day) 1848 (Year)

7. AGE: 72 Yrs. 2 Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Emmons.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Elizabeth Sandrus

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Olive Swift
(Address) Salmon Idaho

15.
Filed 9/1.0 1920. M. Hering Greene
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August (Month) 9th (Day) Monday 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from last 191 10 years to ..... 191...
that I last saw her alive on Aug 7th 1920
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation

.....(Duration) ...10. Yrs..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ...2. Yrs..... mos. ..... ds.

(Signed) F. S. Wright M. D.
8/9 1920. (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 8-11" 1920

20. UNDERTAKER: W. C. Forbes
ADDRESS: Salmon Ida

should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31535

Registered No. .....

1. PLACE OF DEATH.

County of Lewis

City of Sorgeant

Registration District No. 60

Primary Registration District No. 2179

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Kelly

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	single

6. DATE OF BIRTH. unknown.
(Month) (Day) (Year)

7. AGE Probably about 70 yrs. Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Laborer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Penn

10. NAME OF FATHER unknown.

11. BIRTHPLACE OF FATHER (State or Country) unknown.

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A M Brokaw
(Address) Sorgeant Ida

15. Filed 8/18 1920 P E Dewey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h[illegible] alive on Aug 16 1920, and that death occured on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris
Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ———

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) P E Dewey M. D.

8/18 19... (Address) Sorgeant Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
F O O Cemetery	8/18 1920
20. UNDERTAKER	ADDRESS
Stan Wells & Co	Sorgeant

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 60
Primary Registration District No. 2127
File No. 31536
Registered No. 14

1. PLACE OF DEATH.
County of Lemhi
City of Cowgurnt
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Wyomi Treadwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	married

6. DATE OF BIRTH.
Apr (Month) 8 (Day) 1859 (Year)

7. AGE
61 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Sierra Co Kansas (Ark)

10. NAME OF FATHER John Treadwell

11. BIRTHPLACE OF FATHER (State or Country) Tenn.

12. MAIDEN NAME OF MOTHER — Teal.

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs G M Treadwell
(Address) Cowgurnt

15. Filed 8/4 1920 R. G. Dunlap Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1920, to Aug 3 1920, that I last saw h[illegible] alive on Aug 3 1920, and that death occured on the date stated above, at 8:10a M.

The CAUSE OF DEATH* was as follows:
Acute Endocarditis

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Myocarditis

(Duration Some (?) yrs. ..... mos. ..... ds.
(Signed) R. G. Dunlap M. D.
8/4 1920 (Address) Cowgurnt Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fletcher cemetery — DATE OF BURIAL: 8/4 1920

20. UNDERTAKER: Shaw Bros — ADDRESS: Cowgurnt

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2428
File No. 31537
Registered No. ____

1. PLACE OF DEATH.
County of Lewis
City of Kamiah
(No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur Hayes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
March 29 (Month) (Day) 1903 (Year)

7. AGE
17 Yrs. 4 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Kamiah Idaho

10. NAME OF FATHER
Harry Hayes

11. BIRTHPLACE OF FATHER
(State or Country) Idaho

12. MAIDEN NAME OF MOTHER
Maria Moffett.

13. BIRTHPLACE OF MOTHER
(State or Country) Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Harry Hayes
(Address) Kamiah Ida

15. Filed 8/25 1920
C. J. Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 25 1920, to August 25 1920, that I last saw h.im alive on August 24 1920, and that death occured on the date stated above, at 3 57 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) One Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration One yrs. ____ mos. ____ ds.

(Signed) W. Taylor, M. D.

8-21 1920 (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Indian Cem. No 1. DATE OF BURIAL: 8/26 1920

20. UNDERTAKER: C. J. Johnson ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 2428
File No. 31538
Registered No.

1. PLACE OF DEATH
County of Idaho
City of Near Kamiah Ida
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Lashly

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: April (Month) 4 (Day) 1870 (Year)

7. AGE: 50 Yrs. 4 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sawyer
(b) General nature of industry, business or establishment in which employed (or employer): Lumber Mill

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Joe E. Lashley

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charley Lashley
(Address) Orofino Ida

15. Filed 10/4 1920 C J Johnson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2nd 1920, to Sept 2 19..., that I last saw h— alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accident

Sudden
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. S. Bryan M. D.

Sept. 3 1920 (Address) Kamiah Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Woodland — DATE OF BURIAL: 9/6 1920

20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

31539

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Madison

City of Rexburg

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. 69

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Neoma Flamm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. August 3 1920 (Month) (Day) (Year)

7. AGE: ... Yrs. ... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Rexburg Idaho

10. NAME OF FATHER: John Daniel Flamm

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah

12. MAIDEN NAME OF MOTHER: Francis Rigby

13. BIRTHPLACE OF MOTHER (State or Country): Newton Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. D. Flamm

(Address) .....

15. Filed 8/5/20 191.... G G Esplin Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 5 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1920, to Aug 5 1920, that I last saw her alive on Aug 4 1920, and that death occured on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Premature Birth —

..... (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Birth Pressure

..... (Duration ... yrs. ... mos. ... ds.

(Signed) Parley Nelson M. D.

8-5 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg City Cemetary — DATE OF BURIAL: Aug 5 1920

20. UNDERTAKER: Perry D Johnson — ADDRESS: Rexburg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31541

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. 70
Registered No.

1. PLACE OF DEATH
County of Madison
City of Burton
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis H Gunnell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: May (Month) 8 (Day) 1907 (Year)

7. AGE: 18 Yrs. 3 Mos. 22 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo B Gunnell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jennette Hill

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo B Gunnell
(Address) Rexburg Ida R2 #1

15. Filed Aug 31 1920 G Gaspe Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30th 1920, to Aug 30th 1920
that I last saw him alive on Aug 30th 1920,
and that death occurred on the date stated above, at 5P M.
The CAUSE OF DEATH* was as follows:

Chronic nephritis

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Louise F Tuck M. D.
8/31 1920 (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL Sept 1 1920

20. UNDERTAKER Rexburg Furn Co. ADDRESS Rexburg
Chas T Gillette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

31542

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Madison
City of Rexburg.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100
Primary Registration District No. 2178.

File No. 67
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Daniel Hopkins.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 6 (Day) 1841 (Year)

7. AGE: 78 yrs. 8 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic work
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Clinton, County Ohio

10. NAME OF FATHER: Ezekiel Hopkins

11. BIRTHPLACE OF FATHER (State or Country): United States

12. MAIDEN NAME OF MOTHER: Lydia Garrett.

13. BIRTHPLACE OF MOTHER (State or Country): New Jersey.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
Mary Hopkins C.C. Martin
(Informant)
(Address) Rexburg Idaho

15. Filed Aug 14 1920 G.L. Keeler
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 12 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 11 1920, to Augs 12 1920, that I last saw h. i. m. alive on August 12, 1920. and that death occurred on the date stated above, at 7 ½ P.M.

The CAUSE OF DEATH* was as follows:
Acute Dilatation
(Prostration)

(Duration) ..... yrs. ..... mos. 18 ds.
Contributory (Secondary): Old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A.L. Martin M. D.
Aug 15 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? Ovariotomy at Pocatello June 25-1920 Idaho
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: .....
DATE OF BURIAL: Aug 15 1920.

20. UNDERTAKER: David Young
ADDRESS: Rexburg Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

31543 Frozen

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. 32

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laurence E Nelson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1914 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A E Nelson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Bula Williams

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A E Nelson

(Address) Rupert Idaho

15. Filed Aug 28 1920

E. E. Elmore
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29 1920, to [redacted] that I last saw h[redacted] alive on July [redacted] and that death occurred on the date stated above, at [redacted] M.

The CAUSE OF DEATH* was as follows:

Fracture at base of skull

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

19..... (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Aug 1 1920

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31544

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 51
Registered No.

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha L Long
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 15 (Day) 1 (Year)

7. AGE: 16 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Maid
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Wilburn Long

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Lana Agee

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilburn Long
(Address) Rupert Idaho

15. Filed Sept. 2 1920 E A Elmore
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19..., to ——— 19...
that I last saw h... alive on ——— 19...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) E A Elmore M. D.
9-2 1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert
DATE OF BURIAL: 8-5 1920

20. UNDERTAKER: W B Robinson
ADDRESS: Rupert Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31545

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 0 0
Registered No.

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archibald R. Young.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 11 (Day) 1850 (Year)

7. AGE: 70 Yrs. Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: James Young.

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Margret Henderson

13. BIRTHPLACE OF MOTHER (State or Country): Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cora May Young
(Address) Rupert Idaho

15. Filed Sept. 6 20 E. H. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 10 1920, to Aug 13 1920, that I last saw him alive on Aug 12 1920, and that death occurred on the date stated above, at 4 a. M.

The CAUSE OF DEATH* was as follows:
Acute Intestinal Obstruction

(Duration) Yrs. mos. ds.
Contributory (Secondary) Post-Operative Adhesions
(Duration) yrs. mos. ds.

(Signed) E. H. Elmore M. D.
9-2 1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Aug 19 20

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
File No. 31546
Registered No. 438

1. PLACE OF DEATH
County of Nez perce
City of Lewiston
(No. East Lewiston St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel George Seaman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): M / Married

6. DATE OF BIRTH: Aug 26, (Month) (Day) 1849 (Year)

7. AGE: 70 Yrs. 11 Mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Samuel Seaman

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Mary Grim

13. BIRTHPLACE OF MOTHER (State or Country): Ga.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Seaman
(Address) Lewiston, Idaho

15. Filed Sept 10 1920 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 1 (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 5.00 P.M.
The CAUSE OF DEATH* was as follows:

Chronic Bronchial Asthma

(Duration) 16 Yrs. mos. ds.
Contributory (Secondary) Senility
(Duration) yrs. mos. ds.

(Signed) C W Stuart M. D.
192 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho
DATE OF BURIAL: 8.3. 1920

20. UNDERTAKER: C J Vassar
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31547
Registered No. 439

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 1025, 8th St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matie Blomquest

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Married

6. DATE OF BIRTH: Mar (Month) 13 (Day) 1875 (Year)

7. AGE: 45 Yrs. 4 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: ~~Not~~ Barrett

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Susan Kahr

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Blomquest
(Address) Lewiston Idaho

15. Filed Sept 1 19[illegible]
Susan E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920, to Aug 1st 1920, that I last saw her alive on July 16 1920 and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. R. Molley M. D.
19 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston	8-3-1920
20. UNDERTAKER: C. J. Vassar	ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Molley

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31548

Registered No. 440

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston,

(No. 510 6th St. or Ward St.)

If death occurred away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Henry Alexander

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W	Widowed

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1851 (Year)

7. AGE: 69 Yrs. 5 Mos. 25 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ontario

10. NAME OF FATHER Robert Alexander

11. BIRTHPLACE OF FATHER (State or Country) Glascow Scot

12. MAIDEN NAME OF MOTHER A. McCauley

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur O. Alexander

(Address) Lewiston Idaho

15. Filed Sept-10 1920 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 3rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1920 to Aug 3rd 1920 that I last saw him alive on Aug 3rd 1920, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Uremic Poisoning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Bruce M. D.

1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: J. Wasson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 96

Primary Registration District No. 1009

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31549

Registered No. 141

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston (No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Uriah Conner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	Indian	Single

6. DATE OF BIRTH: April (Month) 5 (Day) 11 (Year)

7. AGE: 4 Yrs. 3 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lapwai D.

10. NAME OF FATHER G. E. Conner

11. BIRTHPLACE OF FATHER (State or Country) Ida.

12. MAIDEN NAME OF MOTHER Lizzie Lawyer

13. BIRTHPLACE OF MOTHER (State or Country) Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. E. Conner

(Address) Pendleton Ore

15. Filed Sept 19 1920 Susan E. Brune Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 26 1920, to Aug 4 1920, that I last saw him alive on Aug 4 1920, and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows: Tuberculer meningitis

..... (Duration) ..... Yrs. ..... mos. 4½ ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Paul W. Johnson M. D.

8/4 1920 (Address) Lewiston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lapwai	Sept 1920

20. UNDERTAKER	ADDRESS
Nelson	Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31550
Registered No. 142

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96
Primary Registration District No. 1009
(No. 804 — 8th ave St.)

2. FULL NAME Homer Whitcomb

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1891 (Year)

7. AGE: 29 Yrs. — Mos. 7 ds. —
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Auto Agent
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James W Whitcomb

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Sallie Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James W. Whitcomb
(Address)

15. Filed Sept 10 1920 — Frank E Bauer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 17 1920, that I last saw h[im] alive on Aug 17 1920, and that death occurred on the date stated above, at 12 00 P.M.

The CAUSE OF DEATH* was as follows: General Pulmonary Tuberculosis

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary): Same

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L. Whit[illegible] M. D.

Aug 17 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: Sept 19, 1920

20. UNDERTAKER: C Hasson — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

or white

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31551
Registered No. 4443

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 802 - 3rd st, St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mr. E. W. Barnes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 13 (Day) 37 (Year)

7. AGE: 83 Yrs. — Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ldr,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas L. Frazier
(Address) Lewiston Idaho

15. Filed Sept 10 1920 Susan E Bruce Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
(Did not arrive until few minutes after death.
Cardio-Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Paul W Johnson M. D.
8/19 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida — DATE OF BURIAL: Aug 19 1920

20. UNDERTAKER: Hansen — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31552
Registered No. 444

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St Joseph Hospital)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank P. Patterson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept (Month) 28 (Day) 1900 (Year)

7. AGE: 19 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: J. E. Patterson

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Caroline Peyton

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John E. Patterson
(Address) Missoula, Montana

15. Filed Sept 10 1920
Duane E. Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1920, to Aug 18 1920, that I last saw h... alive on Aug 18 1920 and that death occurred on the date stated above, at 3:45 P.M.

The CAUSE OF DEATH* was as follows:
Gun shot wound of abdomen

(Duration) ... Yrs. ... mos. 3 ds.
Contributory (Secondary) Peritonitis
(Duration) ... yrs. ... mos. 1 ds.

(Signed) E G Broderick M. D.
Aug 18 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Missoula Int — DATE OF BURIAL: 8-20 1920

20. UNDERTAKER: C J Hogan — ADDRESS: Lewiston I.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31553
Registered No. 448

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. Whiter Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clyde James Vassar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 28 (Day) 1875 (Year)

7. AGE: 45 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Undertaker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: J O Vassar

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Isabelle McLelan

13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E M Vassar
(Address) Pomeroy Wash

15. Filed Sept 10 1920 Susan E Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 17 1920, to Aug 24 1920 that I last saw h~~im~~ alive on Aug 24 1920 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Acute Dilitation of Heart.
General Peritonitis

(Duration) Yrs. ... mos. 6 ds.
Contributory (Secondary) Appendicitis
(Duration) yrs. 2 mos. — ds.

(Signed) E. E. White M. D.
Aug 25 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL 19

20. UNDERTAKER: W B Williamson — ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31554
Registered No. 446

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston (No. 163 Steele Addition St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Otis Darling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 27 (Day) 1876 (Year)

7. AGE: 34 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Charlie Darling

11. BIRTHPLACE OF FATHER (State or Country): Kan

12. MAIDEN NAME OF MOTHER: Annie Blyghton

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Darling
(Address) Palouse Wash

15. Filed Sept-10 1920 Rosan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 28 1920, to Aug. 28 1920, that I last saw h— alive on Aug. 28 1920, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Acute Alcoholic poisoning
— accidental

(Duration) — Yrs. — mos. 1 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Patterson G. Watson M. D.
8/25 1920 (Address) Lewiston, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash — DATE OF BURIAL: Aug 1920

20. UNDERTAKER: W B. Williamson — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
File No. 31555
Registered No. 447

1. PLACE OF DEATH
County of Nez Perce
City of Co Farm
(No. County Farm St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elias Fawcett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Aug (Month) 17 (Day) 1832 (Year)

7. AGE: 88 Yrs. — Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Elias Fawcett Sr

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grant Henderson
(Address) County Farm

15. Filed Sept 14, 1920 — Susan E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Aug 30 1920
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 8:00 A.M.
The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John N. Alley M. D.
19 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: Aug 31 1920

20. UNDERTAKER: W L Williamson — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 31556
Registered No. 445

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston (No. St. Joseph Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Merle Leslie Newman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Infant

6. DATE OF BIRTH: March (Month) 20 (Day) 1917 (Year)

7. AGE: 6 — 6 Yrs. 5 Mos. 11 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Whitebird Ida

10. NAME OF FATHER Grover C. Newman

11. BIRTHPLACE OF FATHER (State or Country) Dayton Wn.

12. MAIDEN NAME OF MOTHER Zola Gorsline

13. BIRTHPLACE OF MOTHER (State or Country) Salem Oreg

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Grover C. Newman
(Address) Clarkston Wash

15. Filed Sept 10 1920 — Susan E. Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1920 to Aug 31 1920 that I last saw h... alive on Aug 31 1920 and that death occurred on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) Yrs. ... mos. 10 ds.

Contributory (Secondary) Osteo myelitis R Tibia (Duration) ... yrs. ... mos. 10 ds.

(Signed) E. G. Bruesch M. D.

Aug 31 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clarkston Wash	8/31 1920

20. UNDERTAKER	ADDRESS
H. P. Merchant	Clarkston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 1007
File No. 31557
Registered No. 173

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie M. Martin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: ~~June~~ Sept 16 (Month) (Day) 1 (Year)

7. AGE: 65 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J. M. Hutchison

11. BIRTHPLACE OF FATHER (State or Country): not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Martin
(Address) Craigmont, Idaho

15. Filed Sept 10 1920 Thom E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 30 1920 to July 31 1920 that I last saw h er alive on July 31 1920 and that death occurred on the date stated above, at 7-30 A M.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Clinton S Braddock M. D.

Jul 31 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston — DATE OF BURIAL: 8/4 1920

20. UNDERTAKER: Bassan — ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Onida
City of Malad.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 31558
Registered No. 30
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jarrett Burris.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 6 (Day) 1900 (Year)

7. AGE: 20 yrs. 5 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Civil Engineer

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER F. W. Burris.

11. BIRTHPLACE OF FATHER (State or Country) Ill.

12. MAIDEN NAME OF MOTHER Mary Bruns

13. BIRTHPLACE OF MOTHER (State or Country) Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Burris
(Address) Caldwell, Idaho

15. Filed Aug 31 1920 R. T. Mauer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1920, to Aug 17 1920 that I last saw h im alive on Aug 17 1920 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) ..... yrs. ..... mos. 3 ds.
Contributory (Secondary) Endocarditis (Chronic)
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) R. T. Mauer M. D.
19 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Caldwell, Idaho | DATE OF BURIAL: Aug 19 1920

20. UNDERTAKER: J. Guy Benson | ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 31559
Registered No. 31
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David C. Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Oct (Month) 16 (Day) 1841 (Year)

7. AGE
78 yrs. 10 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer

9. BIRTHPLACE
(State or Country) Wales

10. NAME OF FATHER
David Jones

11. BIRTHPLACE OF FATHER
(State or Country) Wales

12. MAIDEN NAME OF MOTHER
Ann Lewis

13. BIRTHPLACE OF MOTHER
(State or Country) Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David S. Jones
(Address) Malad, Idaho

15.
Filed Aug 31 1920
R. M. Lewis M. D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1, 1920, to Aug 19, 1920, that I last saw him alive on Aug 19, 1920, and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:
General Debility

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
..... (Duration) 4 yrs. ..... mos. ..... ds.
(Signed) J. E. Gallop M. D.
8-19 1920 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Malad	Aug 22 1920
20. UNDERTAKER	ADDRESS
J. Guy Benson	Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

GYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Custer
City of St Hans
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 31560
Registered No. 32
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margret Stephens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Widowed

6. DATE OF BIRTH: Feb (Month) 3 (Day) 1832 (Year)

7. AGE: 88 yrs. 6 mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Housewife

9. BIRTHPLACE (State or Country) Wales

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John L Jones
(Address) Malad

15. Filed Aug 31 1920 R M Maxwell Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 26 1920 to Aug 26 1920 that I last saw h ex alive on Aug 26 1920 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Uraemia decay.

(Duration) 1 yrs. mos. ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Kerns M. D.
19 ..... (Address) Malad Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: St John — DATE OF BURIAL: Aug 29 1920

20. UNDERTAKER: J Guy Benson — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 43

Primary Registration District No. 2120

File No. 31562

Registered No.

1. PLACE OF DEATH.

County of Owyhee

City of Givens Springs (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Erwin H. Hoffman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: December (Month) 18 (Day) 1920 (Year)

7. AGE: 40 yrs. 8 mos. ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ranch-hand (on
(b) General nature of industry business, or dstablishment in which employed (or employer): the Blacketack Ranch

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) (Sgd.) Adam Blacketack
(Address) Givens Springs, Idaho

15. Filed Aug. 30, 1920 W. H. Schuyler, M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 191..., to ——— 191..., that I last saw h— alive on ——— 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Contusion of head, fracture of skull, dislocation neck, etc (Violent death) attacked by angry bull, (no horns, dehorned) — no witness.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Schuyler, Coroner Owyhee Co. M. D.

Aug. 28 1920 (Address) Murphy, Owyhee Co., Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Caldwell, Idaho	Aug. 28, 1920.

20. UNDERTAKER	ADDRESS
Peckham,	Caldwell Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired, 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of ..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis,* etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy", "Collapse," "Coma," "Convulsions," "Debility, ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*", "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

9 # 2

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 43
Primary Registration District No. 2120
File No. 31563-A

1. PLACE OF DEATH.
County of Owyhee
City of Murphy (No. ....., ... St.)
Registered No. .....
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Celina Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: March (?) 1844 (Month) (Day) (Year)

7. AGE: 75 yrs. 4 mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Thomas Gregg

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: Margaret Walsh

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret Swan
(Address) Murphy, Idaho

15.
Filed August 24, 1920 W. N. Schuyler M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 22 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 22 1920, to Aug. 22 1920, that I last saw her alive on August 22 1920 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
Heart Disease, - Aortic Stenosis.

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Pneumonia of last winter
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. N. Schuyler M. D.
Aug 24 1920 (Address) Murphy, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Manson, Iowa
DATE OF BURIAL: Aug 27 1920

20. UNDERTAKER: Robinson
ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31563 B

1. PLACE OF DEATH.
County of Owyhee
City of Grand View.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leonidas Claude Jones.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White, American
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH: — (Month) — (Day) 1874 (Year)

7. AGE: 46 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: "Bee keeper or hunter,"
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin (?)

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Information given Coroner at Grand
(Address) View, by friends of deceased

15. - no death certificate seems to have been filed with local registrar, - except Coroner's Report.
Filed ..... 191...
Believe it was forwarded direct to Boise.
W. H. Schuyler M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: September 15, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15 1920, to Sept. 15, 1920, that I last saw him alive on Sept. 15, 1920 and that death occurred on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows: Coroner's Inquest:- Two gun shot wounds in forehead & two above heart in left chest, - from 15/22 rifle, with murderous intent. Death instantaneous"

..... (Duration) — yrs. — mos. — ds.

Contributory (Secondary) None

attended by Dr. Wm. J. Erkenbeck, Grand View
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Schuyler M. D.
Sept. 16 1920 (Address) Silver City, (Coroner)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain Home | DATE OF BURIAL 1920

20. UNDERTAKER | ADDRESS Mountain Home

...YORK CO., PTRS. & STRS. 16760

by Dr. Erkenbeck, who was called to Jones when shot.

...of information, should be carefully supplied. AGE should be stated EXACTLY. PRINT... ...ment of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008.
(No. ..... , ... St.)

File No. 31564
Registered No. 29

1. PLACE OF DEATH
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nancy Branham Graham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Dec (Month) 11 (Day) 1834 (Year)

7. AGE: 86 Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Frank Talbot

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jessie Williams
(Address) Payette Idaho

15. Filed July 27 1920 J. C. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1920 to July 24 1920 that I last saw her alive on July 24 1920, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 3½ ds.
Contributory (Secondary) Arterio Sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.
7/26/1920 (Address) Payette Ida

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal** or **Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: July 27 1920
20. UNDERTAKER: Glenn C Landon
ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 31567
Registered No. 32

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessie Jane Frazier
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug 3 1890 (Month) (Day) (Year)

7. AGE: 30 yrs. — mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Alonzo D. Giddings

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Katherine Burley

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): T H Frazier
(Address):

15. Filed Aug. 19 1920 191 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 16 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15 1920, to Aug. 16 1920, that I last saw her alive on Aug. 16 1920 and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:
Eclampsia

(Duration) ..... yrs. ..... mos. 1/4 ds.
Contributory (Secondary): Edema of lungs
(Duration) Three hours yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.
8/18/1920 (Address) Payette, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida | DATE OF BURIAL: Aug 19 1920

20. UNDERTAKER: O. H. Cadair | ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

File No. 31569
Registered No. 34
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Abraham Wodle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: May (Month) 28 (Day) 1833 (Year)

7. AGE: 87 yrs. 5 mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Henry Wodle

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Brumbaugh

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Minnie Williams
(Address) Weiser Idaho

15. Filed Sept 2 1920 191.... J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug. (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920 to Aug 28 1920, that I last saw him alive on Aug 28 1920 and that death occurred on the date stated above, at 3:00 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Nephritis

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. F. Avery M. D.
Sept 1920 (Address) Payette, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Ida — DATE OF BURIAL: Sept 2 1920

20. UNDERTAKER: O. F. Adam — ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 1976O

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 5
County of Payette Primary Registration District No. 1009
City of New Plymonth (No. ....., ... St.) File No. 31570
If death occurs away from usual residence, give facts called for under special information. Registered No. 8 10
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David J Campbell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 26 (Day) 1846 (Year)

7. AGE: 73 yrs. 11 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Mark Campbell

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary A Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Frank
(Address) Payette Idaho

15. Filed Aug 23 1920 Wm J. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1920, to Aug 20 1920
that I last saw h... alive on Aug 20 1920
and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Pernicious Anemia

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) William J Wray M. D.
8/23 1920 (Address) Oakland Ore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: New Plymouth | DATE OF BURIAL: Aug 22 1920

20. UNDERTAKER: J W Adair | ADDRESS: Payette

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of near Nbr Plymouth (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5
Primary Registration District No. 2009

File No. 31571
Registered No. 11

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Evaline M. Woodward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widowed

6. DATE OF BIRTH
June (Month) 15 (Day) 1837 (Year)

7. AGE
83 yrs. 2 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Jas Steele

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Elizabeth McLean

13. BIRTHPLACE OF MOTHER (State or Country) Penn -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Anna Emerson
(Address) Boise Ida

15.
Filed Aug 29 1920 Wm J. Drysdale Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from for several years 191.., to ..... 191..., that I last saw her alive on Aug 26 1920, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis -

(Duration) many yrs. ..... mos. ..... ds.

Contributory (Secondary) Myocarditis

(Duration) many yrs. ..... mos. ..... ds.

(Signed) Wm J. Drysdale M. D.

8-27 1920 (Address) Nbr Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Boise Ida | DATE OF BURIAL: Aug 28 1920

20. UNDERTAKER: D H Adair | ADDRESS: Payette Ida -

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 10760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

31573

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25
Primary Registration District No. 2072
File No. 3
Registered No. 162

1. PLACE OF DEATH.
County of Power
City of American Falls (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Higgins
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Aug (Month) 8 (Day) 1920 (Year)

7. AGE: ... yrs. ... mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.? 2 hrs.

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER William E Higgins

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Ethel Tyler

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Higgins
(Address) American Falls Ida

15. Filed 8/12 1920 R. J. Nott Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 8 1920, to Aug 8 1920, that I last saw h e alive on Aug 1920, and that death occurred on the date stated above, at 9 43 10 M.

The CAUSE OF DEATH* was as follows:
Atelectasis
2 hrs
(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) —
(Duration) ... yrs. ... mos. ... ds.

(Signed) M. C. Martinson M. D.
8/8 1920 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Ida
DATE OF BURIAL: Aug 9 1920

20. UNDERTAKER: Friends
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

31574

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 1011

File No.

County of Shoshone

City of Wallace (No. Residence No. If in a Hospital or Institution, give its NAME instead of street and number.) Grove

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah E. Cross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F.	white	widowed

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE

73 yrs. mos. ds.

IF LESS than 1 day how many hrs. or mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work housework

(b) General nature of industry business, or establishment in which employed (or employer) at home.

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Frank DeGarmo

11. BIRTHPLACE OF FATHER (State or Country) not given

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Cross

(Address) Wallace Ida

15. Filed Aug 2 1920 J. L. Jenks Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH August 2 1920

(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920 to Aug 2 1920 that I last saw h[illegible] alive on Aug 2 1920 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows: Cerebral Apoplexy

(Duration) yrs. mos. 3/4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) D. Mavery M. D.

Aug 3 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence. Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene City Cd. DATE OF BURIAL: Aug. 4 1920

20. UNDERTAKER: Harry Thompson ADDRESS: Wallace Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

City of Wallace (No. Providence Hospital St.) Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Rosa Kocyan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June (Month) 21 (Day) 1892 (Year)

7. AGE: 28 Yrs. 1 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: John Konljan

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Noinformation

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Andy Kocyan
(Address) Kellogg, Idaho

15. Filed Aug 8 1920 F. L. Jenkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Aug 3 1920, that I last saw h alive on Aug 1st 1920, and that death occured on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Septicaemia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. L. Jenkins M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kellogg Idaho	Aug 8 1920

20. UNDERTAKER	ADDRESS
Bruce G. Worsted	Wallace Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70

Primary Registration District No. 1014

File No. 3576 A

(No. Providence Hospital)

Registered No. 40

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clara Ashcroft

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 15 (Day) 1860 (Year)

7. AGE 60 Yrs. 1 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pa.

10. NAME OF FATHER Barney Douglass

11. BIRTHPLACE OF FATHER (State or Country) Pa.

12. MAIDEN NAME OF MOTHER Anna Douglass

13. BIRTHPLACE OF MOTHER (State or Country) Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Floyd Ashcroft

(Address) Lane Idy

15. Filed 8/12/20 1920

F. L. Shepherd
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 10 1920, to Aug 11 1920, that I last saw h.. alive on Aug 11 1920, and that death occured on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) D. Mowery M.D.

Aug 12 1920 (Address) Wallace

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Medimont | DATE OF BURIAL: Aug 12 1920

20. UNDERTAKER: D.G. Marshall | ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

File No. 31576 B

City of Wallace

(No. Providence Hospital)

Registered No. 44

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Milio Garilano

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	single

6. DATE OF BIRTH

(Month) (Day) 1 (Year)

7. AGE

8 yrs. — mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... student

(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Mullan Idaho

10. NAME OF FATHER Joseph Garilano

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER Mary Boda

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Garilano

(Address) Mullan Idaho

15.

Filed Aug 17 1920 F. L. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw him alive on Aug 15 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebro Spinal Meningitis

(Duration) ..... yrs. ..... mos. 14 ds.

Contributory .....

(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19... (Address) C. S. Elbon Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence Mullan Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mullan Ida	Aug 17 1920

20. UNDERTAKER	ADDRESS
Harry Thompson	Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31577

Registered No. 43

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

(No. Provide Hosp.)

Registration District No. 70

Primary Registration District No. 1014

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Collis Hoy Lehman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 13 (Day) 1920 (Year)

7. AGE — Yrs. — Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E. H. Lehman

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Gladys Collis

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J Collis

(Address) Wallace

15. Filed Aug 16 1920 F. L. Jenkins, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Internal Congenital Defect

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Carr M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida. | DATE OF BURIAL: Aug 17 1920

20. UNDERTAKER: E. Morstell | ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31578
Registered No. 48

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 1011
(No. Wallace Hospital St.)

2. FULL NAME Julia Erickson

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: October 29 1889 (Month) (Day) (Year)

7. AGE: 31 yrs. 10 mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Galena, Kansas

10. NAME OF FATHER: Samuel Rowe

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: Anna Malmquist

13. BIRTHPLACE OF MOTHER (State or Country): not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Esther Simpson
(Address) Wallace Hospital
Wallace, Idaho.

15. Filed Aug 21 1920 F. L. Finley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August 18 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1920 to August 18 1920 that I last saw h[illegible] alive on August 18 1920 and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Duration) yrs. mos. 3 days.
Contributory (Secondary) Chronic Interstitial Nephritis
(Duration) years mos. days.
(Signed) W. Frank C. Graves M. D.
19 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. In the State ..... yrs. ..... mos. 5 days.
Where was disease contracted if not at place of death? Murdock
Former or usual residence Genesee Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Aug 21 1920

20. UNDERTAKER: Harry Thompson
ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 1011
File No. 31579
Registered No. 44

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Providence Hospital)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dan Sullivan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
45 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... miner
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dan Deany
(Address) Burke Ida.

15.
Filed Aug 31 1920 F. L. Hunter
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1920 to Aug 30 1920
that I last saw h... alive on Aug 30 1920
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.
Contributory
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. Mowery M. D.
Aug 31 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Sept 2nd 1920

20. UNDERTAKER: Harry Thompson
ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 18760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital St.)

File No. 31580
Registered No. 31
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rena Sherman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE: 7 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Albert Sherman

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Beatrice Padfield

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Sherman
(Address) Burke Ida

15.
Filed June 3 1920 F. A. Dunn
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June 1 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1920 to June 1 1920
that I last saw him alive on May 31 1920
and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Diphtheria

(Duration) yrs. mos. 5 ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) K B Stockslager M. D.
6/5 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence: Burke Ida

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: June 6 1920

20. UNDERTAKER: Henry Thompson ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31581

Registered No. 34

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 1211

(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Louis John Claflin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. April (Month) 1st (Day) 1881. (Year)

7. AGE: 39 Yrs. 2 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: lumber mill worker

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Louis B. Claflin

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Anna McDermott

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs S. W. Brothers,

(Address) Basin, Mont.

15. Filed June 13 1920 J. L. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/8/20 191..., to 6/10/20 191..., that I last saw h.im alive on 6/10/20 191..., and that death occured on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows: Original fracture, Vault of skull with great tearing of brain tissue

(Duration) ... Yrs. ... mos. 2 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. Irwin G. Stimson M. D.

6/12/20 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs...mos...days In the State ...yrs...mos. 2 days

Where was disease contracted if not at place of death? Montana

Former or usual residence Montana

19. PLACE OF BURIAL OR REMOVAL: Mullan Idaho — DATE OF BURIAL: 6/13 1920

20. UNDERTAKER: K. L. Morstell. — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 104
(No. Providence Hospital St.)

File No. 31582
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Earle Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	single

6. DATE OF BIRTH
[redacted] 1
(Month) (Day) (Year)

7. AGE
yrs. mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Wallace Idaho

10. NAME OF FATHER Charles R. Anderson

11. BIRTHPLACE OF FATHER
(State or Country) Missouri

12. MAIDEN NAME OF MOTHER Winifred Gibson

13. BIRTHPLACE OF MOTHER
(State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles R. Anderson
(Address) Salling Montana

15.
Filed June 13 1920 F. L. Jenkins
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH June 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1920 to June 13 1920
that I last saw him alive on June 13 1920
and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Tabes Mesenterica
Congenital Syphilis
(Duration) yrs. mos. 2 ds.
Contributory (Secondary) None
(Duration) yrs. mos. ds.
(Signed) Dr. Mountjoy M.D.
6/14 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence None

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	June 14 1920

20. UNDERTAKER	ADDRESS
Harry Thompson	Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31583

Registered No. 34

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No.

(No. Providence Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jennings Bryan Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Febry 17 (Month) (Day) 1 (Year)

7. AGE 23 Yrs. 3 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cage Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Quartz Mine

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: John E. Taylor

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Rose Smalley

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs J. B. Taylor

(Address) Burke, Ida.

15. Filed June 19 1920 F L Dungan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1920, to June 14 1920, that I last saw h[illegible] alive on June 14 1920 and that death occured on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Abscess of brain

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) F. L. Dungan M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: June 19 191[illegible]

20. UNDERTAKER: Bruce & Worstell ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STAR - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 970

Primary Registration District No. 401

(No. Providence Hospital St.)

File No. 31584

Registered No. 35

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Elmina Gregg.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 2 (Day) 1 (Year)

7. AGE: 37 Yrs. 11 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Carl Anderson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Dorothy Marie Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) L. L. Gregg Jr.

(Address) Wallace

15. Filed June 19 1920 F L Dunn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

..... (Month) ..... (Day) 191.... (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 16 1920, to June 17 1920, that I last saw h[illegible] alive on June 17 1920 and that death occured on the date stated above, at 9½ a M.

The CAUSE OF DEATH* was as follows:

Acute Botulism

(Duration) ..... Yrs. ..... mos. 1½ ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) D C Mowery M. D.

6/18 1920 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chicago, Ill — DATE OF BURIAL: 6-19-1920

20. UNDERTAKER: B G Worstell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYRACUSE-YORK CO., PTRS. & BOOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31585

Registered No. 36

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 10 C

(No. 313 Bank St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Jennie A Lonergan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 23 (Day) 1861 (Year)

7. AGE: 59 Yrs. 9 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Lancaster Pa

10. NAME OF FATHER Timothy Balken

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Susan Ruth

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J B Lonergan

(Address) Wallace

15. Filed June 22 1920 F L Jenkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920, to June 21 1920, that I last saw him alive on June 20 1920, and that death occured on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Cerebro-pulmonary

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. L. Jenkins M. D.

19..... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida

DATE OF BURIAL: June 23 1920

20. UNDERTAKER: B. C. Worstell

ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31586
Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1914
(No. Wallace Hospital St.)

2. FULL NAME Porfiro Alveres

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. — (Month) — (Day) — (Year)

7. AGE: 28 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Pasquall Alveres

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Manuella

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Joe Carrillo
(Address) Mullan Ida.

15. Filed June 28 1920 F L Jungen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1920, to June 26 1920, that I last saw h[illegible] alive on June 26 1920 and that death occured on the date stated above, at 7 p M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) — Yrs. — mos. 4 ds.
Contributory (Secondary)
(Duration — yrs. — mos. — ds.

(Signed) [illegible] M. D.
June 26 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida. | DATE OF BURIAL: June 28 1920

20. UNDERTAKER: [illegible] | ADDRESS: Wallace

STAR - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of [illegible] BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 70
Primary Registration District No. 107
File No. 31587
Registered No. 38

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Wallace Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME J. C. Gallahan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: 48 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: M. C. Gallahan

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Martha Arnite

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Howard C. Stanton
(Address) Wallace Idaho

15. Filed June 3 1920
F. L. Jungen
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/24/20 191... to 7/1/20 191...,
that I last saw h.. alive on 7/1/20 191...,
and that death occured on the date stated above, at 8:45 A.M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia -
(Duration) Yrs. mos. 8 ds.
Contributory (Secondary) Acute Alcoholism -
(Duration) yrs. mos. 8 ds.
(Signed) Howard C. Stanton M. D.
7/1/20 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Peru, Indiana — DATE OF BURIAL: July 3 1920

20. UNDERTAKER: P. E. Morstell — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31588

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Providence Hospital)

Registered No. 39
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Shirahdi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	white	single

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
54 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... miner
(b) General nature of industry business, or dstablishment in which employed (or employer) ..... Hotel Keeper.

9. BIRTHPLACE (State or Country) Italy

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (State or Country) Italy

12. MAIDEN NAME OF MOTHER not given

13. BIRTHPLACE OF MOTHER (State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Cancelli
(Address) Wallace Idaho

15. Filed July 1 1920 F. L. Jungy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH July 6 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1919, to July 6 1920, that I last saw h— alive on July 6 1920 and that death occurred on the date stated above, at 2:30 P.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
2
(Duration) yrs. mos. ds.
Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) D. J. Mogerty M. D.
July 7 1920 (Address) City

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL Wallace Ida | DATE OF BURIAL July 8 1920

20. UNDERTAKER Harry Thompson | ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BORS. 18760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1011
(No. Residence 173 Kuna St.)

File No. 31589
Registered No. 40
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Brunell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 58 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Thos. Brunell

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary Cody

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alvin Brunell
(Address) Wallace Ida

15. Filed July 13 1920 F. L. Jungen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July [illegible] 1920 to July 8 1920
that I last saw him alive on July 8 1920
and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows: Pulmonary Tubercu-
losis
(Duration) 1-2 yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) D. P. Flowery M. D.
July 12 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence: Wallace Ida

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida | DATE OF BURIAL: July 13 1920

20. UNDERTAKER: Henry Thompson | ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 1011
(No. Providence Hospital)

File No. 31590
Registered No. 41
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Michael Hooligan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	white	Single

6. DATE OF BIRTH
(Month) 1 (Day) (Year)

7. AGE
93 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Section Foreman
(b) General nature of industry business, or dstablishment in which employed (or employer) ..... Railroad

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER not given

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Cavanaugh
(Address) Providence Hospital Wallace Ida.

15. Filed July 19 1920 F. L. Demsky Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
July (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to July 15 1920;
that I last saw him alive on July 14 1920,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Dementia

(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) — yrs. ..... mos. ..... ds.
(Signed) F. L. Demsky M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	July 19 1920

20. UNDERTAKER	ADDRESS
Harry Tooman	Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

County of Shoshone

Primary Registration District No. 1011

File No. 31591

City of Wallace

(No. Providence Hospital)

Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ronald Thomas Humphrey

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 20 yrs. — mos. — ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New Foundland

10. NAME OF FATHER: Patrick Humphrey

11. BIRTHPLACE OF FATHER (State or Country): New Foundland

12. MAIDEN NAME OF MOTHER: Kate Foran

13. BIRTHPLACE OF MOTHER (State or Country): New Foundland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dale Miller
(Address) Burke Ida

15. Filed July 24 1920 F. L. Jenks Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: July (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 19 1920, to July 22 1920 that I last saw h[illegible] alive on July 22 1920 and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumococcic Cerebro-spinal Meningitis

(Duration) ... yrs. ... mos. 5 ds.

Contributory (Secondary) .....

(Duration) N. ... yrs. ... mos. ... ds.

(Signed) D. M. Howry M. D.

July 24 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence Burke Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida — DATE OF BURIAL: July 26 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31592

Registered No. 57

Registration District No. 122

Primary Registration District No. 2200

1. PLACE OF DEATH.

County of Shoshone

City of Wallace (No. Linn St. Idaho)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Copple

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. July 8 1845
(Month) (Day) (Year)

7. AGE 75 Yrs. 6 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Sanford H Copple

11. BIRTHPLACE OF FATHER (State or Country): Indiana

10. &11 amended 7-27-83 JRA

12. MAIDEN NAME OF MOTHER: Case

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address) Sarah Mayes Kellogg Ida

15. Filed July 28 1920 H. C. Mowry Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1920, to July 28 1920, that I last saw h[illegible] alive on July 27 1920, and that death occured on the date stated above, at 2 15 P M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration yrs. 4 mos. ..... ds.

(Signed) C B Higenbotham M. D.

7/30 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace Idy — DATE OF BURIAL: July 30 1920

20. UNDERTAKER: [illegible] — ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics, Standards, and Local Health Services

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

State of LOUISIANA
Parish ~~County~~ of BOSSIER } ss.

Certificate No. 20-31592
Date Filed July 28, 1920

The undersigned does solemnly swear that certain facts on the certificate of Death

for Elizabeth Copple (Name on Original Certificate) who died (Was Born, Died, etc.) on July 28, 1920 (Date of Event)

in Wallace ID (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
Item # 10 Father's name	Sanford H. Copple	
11 Father's Birthplace	Indianna	
12 Mother's name	Case	
13 Mother's Birthplace	Tenn.	

Subscribed and sworn to before me this 1st day of April, 19 83

Notary Public, Lena A. Young

~~Residing~~ Office - 301 Benton Rd., Bossier City, LA 71111

My commission expires at death

(Seal)

Mrs. Lucille T. Stallings
Signature of Applicant

4630 Tacoma Blvd., Shreveport, LA 71107
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____
County of _____ } ss.

(Must be completed __)
(Is not necessary XX)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____, 19__.

Notary Public, _____

Residing at _____

My commission expires _____

(Seal)

Mrs. Lucille T. Stallings
Supporting Signature

_____
Street Address, City, State

Corres. JRA 11-22-82

NOV 8 1988

Affidavit sent 4-19-83, returned signed but not completed. Documentation supports paternity correction only. JRA

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 172
Primary Registration District No. 2206
File No. 31593
Registered No. 52

1. PLACE OF DEATH.
County of Shoshone
City of Wallace
(No. Tamarack Mine St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Douglas Haddman

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE
61 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Miner
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Australia

10. NAME OF FATHER
Not given

11. BIRTHPLACE OF FATHER
(State or Country) ..

12. MAIDEN NAME OF MOTHER
..

13. BIRTHPLACE OF MOTHER
(State or Country) ..

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas. Brown
(Address) Wallace Ida

15.
Filed Aug 3 1920 H. C. Mowery
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Suffocation in mine
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Weak heart
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo. W. Walker Justice of the Peace acting in the place of Coroner
Aug 4 1920 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence Tamarack Mine

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Aug 5th 1920

20. UNDERTAKER: Harry Thompson
ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12 2
Primary Registration District No. 2200
File No. 31594
Registered No. 53

1. PLACE OF DEATH.
County of Shoshone
City of Mullan
(No. Residence St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Baumahrich
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE: 38 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: Lucas Baumahrich

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Alice Baumahrich

13. BIRTHPLACE OF MOTHER (State or Country): Austria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anne Baumahrich
(Address) Mullan Ida

15. Filed Aug 11 1912 H. A. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
August (Month) 10 (Day) 1912 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 6 1912, to August 10 1912,
that I last saw him alive on August 9 1912
and that death occurred on the date stated above, at 4 Yo AM.
The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) yrs. 9 mos. ds.

Contributory
(Secondary)
(Duration) yrs. mos. ds.

(Signed) James R Brown M. D.
8/10 1912 (Address) Wallace

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence: Mullan Ida

19. PLACE OF BURIAL OR REMOVAL: Mullan
DATE OF BURIAL: Aug 12 1912

20. UNDERTAKER: Harry Thompson
ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31595
Registered No. 54

1. PLACE OF DEATH.
County of Shoshone
City of Mullan
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 122
Primary Registration District No. 2200
(No. Shoshone Mine St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. Wilson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M.	White	married

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
93 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Missouri

10. NAME OF FATHER Robert Wilson

11. BIRTHPLACE OF FATHER
(State or Country) Ohio

12. MAIDEN NAME OF MOTHER Lelia Nelson

13. BIRTHPLACE OF MOTHER
(State or Country) not. given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Chas. Wilson
(Address) Mullan Ida.

15.
Filed Aug 15 1920 H. C. Mowry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Aug (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 191..., to ....., 191...,
that I last saw h..... alive on ....., 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Struck on head by rock
.....
.....
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
† Instantly Dead (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. N. Harris Justice of the Peace M. D.
acting in place of Coroner
Aug 18 1920 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence Mullan 2 Ida

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: Aug 21 1920

20. UNDERTAKER: Harry Thompson ADDRESS: Wallace Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 72 v
Primary Registration District No. 7200
File No. 31596
Registered No. 55

1. PLACE OF DEATH
County of Shoshone
City of Wallace
(No. County Highway St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Norley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1868 (Year)

7. AGE: 52 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Gilmore
(Address) Wallace Ida

15. Filed Aug 23 1920 H. C. Mavery Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14 1920, to Aug 23 1920, that I last saw him alive on Aug 23 1920, and that death occured on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

Broken Compensation
Chr. Valvular Heart Dis

(Duration) Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) James A Bean M. D.
8/25 1920 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Aug 1920

20. UNDERTAKER: B. L. Marshall. — ADDRESS: Wallace

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 2206
File No. 31597
Registered No. 56

1. PLACE OF DEATH.

County of Shoshone
City of ~~Wallace~~ Mullan (No. Morning Mine St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert J. Lofts,

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 22 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electric Motorman
(b) General nature of industry, business, or establishment in which employed (or employer): General Mining.

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Robert H. Lofts

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Federal Mining Co
(Address) Wallace Ida

15. Filed Aug 28 1920 H C Mowry Local Registrar

SYMS - YORK CO., PTRS. & ENGS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Accidental Electrocuted at
Morning Mine

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. H. Vallier Justice of the Peace M. D.
acting for the Coroner
Sept 1 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs ... mos ... days In the State ... yrs ... mos ... days
Where was disease contracted if not at place of death? .....
Former or usual residence Toronto Canada Single

19. PLACE OF BURIAL OR REMOVAL: Toronto Canada
DATE OF BURIAL: Sept 2nd 1920

20. UNDERTAKER: Harry Thompson
ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 31598
Registered No.

1. PLACE OF DEATH
County of Jerome
City of Hazelton
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grigg Frank Hampton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January 9th (Month) (Day) 1857 (Year)

7. AGE: 63 Yrs. 7 Mos. 28 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: John Hampton

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Alma Hampton
(Address) Magellan Idaho

15. Filed Sept 9 1920 John J Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from 30 minutes after death 19..., to ..... 19..., that I last saw him alive on Sept 7 1920 and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Endocarditis
(Duration) years yrs. ..... mos. ..... ds.
Contributory (Secondary) Myocardial
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno G Lewis M. D.
9/8 1920 (Address) Hazelton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 9-12 1920

20. UNDERTAKER: E E Ecoff — ADDRESS: Twin Falls

Alexander.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31599
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Myrtle Agnes Ash

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): ~~Single~~

6. DATE OF BIRTH: Jan (Month) 30 (Day) 1899 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): "

9. BIRTHPLACE (State or Country): Lava Hot Spgs, Ida.

10. NAME OF FATHER: Chas. A. Ash

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Ruth Gaston

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ruth Ash.
(Address) Jerome Ida.

15. Filed Aug 23 1920 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 14th 1920, to Aug 20 1920
that I last saw h... alive on Aug 20 1920
and that death occurred on the date stated above, at 1:00 A.M.
The CAUSE OF DEATH* was as follows:

Anemia -

....(Duration) ....Yrs. 6 mos....ds.
Contributory (Secondary) Lymphatic Leukemia
....(Duration) 1 yrs....mos....ds.

(Signed) Duncan C Strawn M. D.
8/22 1920 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Aug 22 1920
20. UNDERTAKER: J. F. Brennan — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 3855
File No. 3160
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca Ann McDougal
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: W (Write the word.)

6. DATE OF BIRTH: April (Month) 30 (Day) 1861 (Year)

7. AGE: 59 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Blair

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Mary Patton

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Lloyd McDougal
(Address) Twin Falls

15. Filed Aug 23 1920
John F. Caughey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9 1920, to Aug 12 1920
that I last saw her alive on Aug 12 1920
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Diabetis

(Duration) 4 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. W. Lee M. D.
Aug 16 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: Aug 16 1920
20. UNDERTAKER: J. Brannan
ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

Dr Leete

CERTIFICATE [redacted]TH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31601
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henery F. Swick
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Widower

6. DATE OF BIRTH: July (Month) 20 (Day) 1843 (Year)

7. AGE: 77 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming -
(b) General nature of industry, business or establishment in which employed (or employer): Retired -

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Thomas Swick

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Catherine Suckerson

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry F. Swick
(Address) Twin Falls, Ida.

15. Filed Aug 23 1920 John T Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1920, to Aug 15 1920, that I last saw h[illegible] alive on Aug 15 1920, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) 7 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H N Leete M. D.

Aug 17 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Aug 17 1920
20. UNDERTAKER	ADDRESS
J J Swanson	Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31602

Registered No.

1. PLACE OF DEATH

County of Twin Falls

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary M Ward

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	Married

6. DATE OF BIRTH: March (Month) 15 (Day) 1860 (Year)

7. AGE: 61 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: nurse

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb

10. NAME OF FATHER: John R Thomas

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Martha Hunt

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William D Ward.

(Address)

15. Filed Aug 21 1920 John Z Coughlan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) — 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1st 1920, to Aug 20 1920, that I last saw h[illegible] alive on Aug 19 1920, and that death occurred on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage from Bowels

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Cancer Liver & Gall Bladder

Chronic jaundice

(Duration) yrs. 7 mos. ds.

(Signed) S L Blanton M. D.

Aug 21 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida | DATE OF BURIAL: 8-21 1920

20. UNDERTAKER: L E Leavitt | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51067

FORM V. S. No. 5-A—25 M. 1-19.

Dwight

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31603
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of ..
(No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera May Nicholson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 6 (Day) 1919 (Year)

7. AGE: 1 Yrs. Mos. 21 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Silver Idaho

10. NAME OF FATHER: L. V. Nicholson

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Ruth Bagley

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lloyd B. Nicholson
(Address) ...

15. Filed Aug 10 1920 John Y. Vaughn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 23 1920, to July 27 1920
that I last saw her alive on July 27 1920
and that death occurred on the date stated above, at 6:50 P.M.
The CAUSE OF DEATH* was as follows:

Peritonitis
(Duration) ... Yrs. ... mos. 2 ds.
Contributory (Secondary) Partial intestinal obstruction
(Duration) ... yrs. ... mos. 6 ds.

(Signed) Frank A. Dwight M. D.
July 27 1920 (Address) Hailey, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: July 29 1920
20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31604

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

Primary Registration District No. 1085

City of [illegible] (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessie Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widow

6. DATE OF BIRTH: 8 (Month) – 7 (Day) – 1910 (Year)

7. AGE: ..... Yrs. ..... Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter

11. BIRTHPLACE OF FATHER (State or Country): [illegible]

12. MAIDEN NAME OF MOTHER: Hazel Jones

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Walter Williams

(Address) Twin Falls

15. Filed Aug 16 1920 John J Corbett Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) – 12 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-12 1926 to 8-12 1926 that I last saw h.... alive on 8-12 1926 and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Liver

Staphylococcus

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T S Mason M. D.

8/16 1926 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 5 mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida. DATE OF BURIAL: 8-9 1926

20. UNDERTAKER: [illegible] ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of .....

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1055

File No. 31605

Registered No. .....

If death occurred in a hospital, institution or camp, write its NAME instead of street and number.

2. FULL NAME Horace S Goldsworthy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Married

6. DATE OF BIRTH: May (Month) 9 (Day) 1 (Year)

7. AGE: 91 Yrs. 3 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: R S Goldsworthy

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Nettie Sherman

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H S Goldsworthy
(Address) Twin Falls, Idaho

15. Filed Aug 20 1920 John H Creighton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) – 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1920, to Aug 20 1920, that I last saw him alive on Aug 20 1920 and that death occurred on the date stated above, at 9 44 M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Syphilis Fever — Chelsea 3 tabs

(Duration) ..... yrs. ..... mos. 40 ds.

(Signed) Duncan L Hunter M. D.

8/9 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: 8 – 22 1920

20. UNDERTAKER: J E Hurst | ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 31606

1. PLACE OF DEATH
County of Jerome
City of Eden (No. ....., ... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME La Fronnes Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec 25 1855
(Month) (Day) (Year)

7. AGE: 64 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Va.

10. NAME OF FATHER: James Davis

11. BIRTHPLACE OF FATHER (State or Country): Va.

12. MAIDEN NAME OF MOTHER: Eliza Redford

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE [redacted] BEST OF MY KNOWLEDGE
(Informant) J. W. Davis
(Address) Eden Idaho

15. Filed Aug 18 1920 John Y. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 10 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10, 1920, to Aug 10 1920 that I last saw him alive on Aug 10 1920 and that death occurred on the date stated above, at 10 M.
The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) ..... Yrs 1 mos. ..... ds.
Contributory (Secondary) Arterio-Sclerosis
(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) W. P. Scroggs M. D.
19..... (Address) Eden, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: Aug 12 1920

20. UNDERTAKER: E. J. Grossman | ADDRESS: Twin Falls Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37 — File No. 31607

City of " " — Primary Registration District No. 1085 — Registered No.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Erwin M. Cook.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March (Month) 18 (Day) 1867 (Year)

7. AGE: 52 Yrs. 6 Mos. 12 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ga.

10. NAME OF FATHER: Levi Cook.

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Mary Lowry

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Erwin M. Cook
(Address) Twin Falls Ida

15. Filed Sept 2 1920 — John L Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1920, to Aug 29 1920
that I last saw h..... alive on Aug 29 1920
and that death occurred on the date stated above, at 6 a m. M.
The CAUSE OF DEATH* was as follows:
Ruptured appendix, general peritonitis

(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) J. W. Wilson M. D.
Aug 31 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greeley Colorado — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. J. Foreman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Twin Falls

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ..... St.)

File No. 31608

Registered No. .....

2. **FULL NAME** Hannah V Pike

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.) Widow

6. **DATE OF BIRTH** January 24 1841
(Month) (Day) (Year)

7. **AGE** 79 Yrs. 2 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Illinois

10. **NAME OF FATHER** John Dugger

11. **BIRTHPLACE OF FATHER** (State or Country) Tennessee

12. **MAIDEN NAME OF MOTHER** Polly Williams

13. **BIRTHPLACE OF MOTHER** (State or Country) Tennessee

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) W. G. Tidy

(Address) Twin Falls Idaho

15. Filed Aug 30 1920

John F Coughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**
8 (Month) 29 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 8/21/1920, **to** 8/29/1920
that I last saw her alive on 8/29/1920,
and that death occurred on the date stated above, at 12-9 **M.**
The CAUSE OF DEATH* was as follows:

Cerebral thrombosis

..... (Duration) ..... Yrs. 8 mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. G. Tidy M. D.

8/29/1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** St Joseph's — **DATE OF BURIAL** 8-30-1920

20. **UNDERTAKER** L. D. Veirth — **ADDRESS** Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31609
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jonathan Van Tassel
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan 28 (Month) (Day) 1845 (Year)

7. AGE: 75 Yrs. 7 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Henry J. Tassel

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mahil da chenaworth

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Minnie A. Tassel
(Address): 411 Walnut St.

15. Filed Sept 4 1920 John H Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep 9 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1920, to Sep 9 1920, that I last saw h[illegible] alive on Sep 2 1920, and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Hodgkin's disease
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) [illegible] M. D.
Sept 3 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idah — DATE OF BURIAL: Sep 5 1920

20. UNDERTAKER: [illegible] — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31610

Registered No.

1. PLACE OF DEATH

County of Twin Falls Registration District No. 37

Primary Registration District No. 1085

City of " " (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred W. Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: (Month) (Day) 1 (Year)

7. AGE: 55 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Fruit & Produce

(b) General nature of industry, business or establishment in which employed (or employer): purchasing Agent

9. BIRTHPLACE (State or Country): Dont know

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. J. Foreman

(Address) Twin Falls

15. Filed Aug 23 1920 John F. Laughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Found dead 19 , to Aug. 20 1920.

that I last saw h alive on 19 ,

and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Heart Failure due to Thrombosis of Coronary Arteries.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John R Morgan M. D.

Aug 21 1920 (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence 637 West 45th Place Los Angeles

19. PLACE OF BURIAL OR REMOVAL: Los Angeles Cal DATE OF BURIAL 19

20. UNDERTAKER: J. J. Foreman ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

Weaver

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls — Registration District No. 37
City of " " — Primary Registration District No. 1083
(No. ____, ____ St.)
File No. 31611
Registered No. ____

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas McMillen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Feb (Month) 2nd (Day) 1871 (Year)

7. AGE: 49 Yrs. 7 Mos. 2 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Motorman.
(b) General nature of industry, business or establishment in which employed (or employer): Street Car.

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: J.A. McMillen

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Priscilla Arnold

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D.A. McMillen
(Address) Twin Falls

15. Filed Sept 8 1920 — John Faughlin, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ 19____, to Sept 3 1920
that I last saw him alive on Sept. 3 1920
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ M. D.
19____ (Address) C.D. Weaver

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Rock Hall Ill. — DATE OF BURIAL 19____

20. UNDERTAKER: P.F. Grosvenor — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2086
File No. 31612
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Bogardus

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Sept. (Month) 28 (Day) 1866 (Year)
7. AGE: 53 Yrs. 10 Mos. 13 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Wife
9. BIRTHPLACE (State or Country) Missouri
10. NAME OF FATHER William Overt
11. BIRTHPLACE OF FATHER (State or Country) Missouri
12. MAIDEN NAME OF MOTHER J Long
13. BIRTHPLACE OF MOTHER (State or Country) Missouri
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Bogardus
(Address) .....
15. Filed June 21 '20 191.... A. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH June (Month) 21 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 25 1920 to June 21 1920
that I last saw h.w. alive on June 21 1920.
and that death occurred on the date stated above, at 5:40 P. M.
The CAUSE OF DEATH* was as follows:
.....
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 21 ds.
Contributory (Secondary) Pulmonary Edema
(Duration) ..... Yrs. ..... mos. .... ds.
(Signed) Frank A. Dwight M. D.
June 23 '20 (Address) Filer, Ida.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Roof cemetery
DATE OF BURIAL: June 23 1920.
20. UNDERTAKER: J E Drake
ADDRESS: Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31513
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 38
Primary Registration District No. 7086
(No. ....., ... St.)

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reatta J. Triggs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widow

6. DATE OF BIRTH. Sept (Month) 19 (Day) 1 (Year)

7. AGE: 87 Yrs. 10 Mos. 16 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER: Thomas Hays

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER: Polly Good

13. BIRTHPLACE OF MOTHER (State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rose A. Johnson
(Address) Filer

15. Filed July 3 20 191.... A. A. Needberry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 29 1920 to June 29 1920 that I last saw her alive on June 29 1920 and that death occurred on the date stated above, at ....., ...M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 6 Yrs. ____ mos. ____ ds.

Contributory (Secondary) Cardiac Paralysis

(Duration) 1 Yrs. ____ mos. ____ ds.

(Signed) Frank A. Wright M. D.

July 6 20 (Address) Filer, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Doof. Cemetery — DATE OF BURIAL: July 4 1920

20. UNDERTAKER: J E Drake — ADDRESS: Filer

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 38

Primary Registration District No. 3686

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3614
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lincoln
City of Filer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel P. Stephens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 3 (Day) 1863 (Year)

7. AGE: 57 Yrs. 11 Mos. 15 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Butcher

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER: Oliver Stephens

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER: Marie Sorenson

13. BIRTHPLACE OF MOTHER (State or Country) Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Stephens
(Address) Filer

15. Filed Aug 16 20 191.... A A Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1920 to July 15 1920
that I last saw him alive on July 15 1920
and that death occurred on the date stated above, at 7:00 P. M.

The CAUSE OF DEATH* was as follows:

Mitral regurgitation
(Duration) Yrs. 1 mos. ..... ds.
Contributory (Secondary) General ascites
(Duration) Yrs. 1 mos. ..... ds.

(Signed) Frank A Dwight M. D.
Aug 26 20 (Address) Filer, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemet Filer — DATE OF BURIAL: Aug 18 20 191...

20. UNDERTAKER: T C Drake — ADDRESS: Filer Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31615
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 7086
(No. ....., ... St.)

2. FULL NAME David D. Beake

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Jan (Day) 21 (Year) 1853

7. AGE: 66 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Miner

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER John Beake

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Barbarba Jefferies

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna D. Beak
(Address) Filer, Idaho

15. Filed Aug. 19 20. 191.... A. A Newberry
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Aug. (Day) 19 (Year) 1920

17. I HEREBY CERTIFY, That I attended deceased from Aug. 14 20 191.... to Aug 19 20 191...
that I last saw h/m alive on Aug. 19 20 191...
and that death occurred on the date stated above, at 11 40 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
Aug 19 20 19.... (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. Cemetery Filer — DATE OF BURIAL: Aug 22 1920

20. UNDERTAKER: H. E. Drake — ADDRESS: Filer

FORM V. S. No. 6-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 31616
Registered No.

1. PLACE OF DEATH

County of Twin Falls
City of Filer
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorraine M. Stephens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 20 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 3 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: H. C. Stephens

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Cythia Barr

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. C. Stephens
(Address) Filer

15. Filed Aug 23 20 19 — P. A. Newberry, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...
that I last saw h... alive on ..... 19...
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Tetanus neonatorum

..... (Duration) ..... Yrs. ..... mos. 2 ds. 3 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. G. Tuke M. D.
8/23/1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sec F Cemetery	Aug 24 1920
20. UNDERTAKER	ADDRESS
J. E. Dick	Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31617
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Burke
(No. ..... , ... St.)

Registration District No. 39
Primary Registration District No. 2087

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John William Hurd Manford

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1900 (Year)

7. AGE: 19 yrs. 11 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Beaver Falls Pa.

10. NAME OF FATHER: J. M. Manford

11. BIRTHPLACE OF FATHER (State or Country): Sharon, Pa.

12. MAIDEN NAME OF MOTHER: Ezbina Stoxdale

13. BIRTHPLACE OF MOTHER (State or Country): Leeds England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J M Manford
(Address) .....

15.
Filed 8-31 1920
J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/28 1920, to 8/30 1920
that I last saw h~~im~~ alive on 8/30 1920
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Concussion of Brain - resulting from Traumatic accidental,
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) X
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Fred Chesley M. D.
8/31 1920 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Ida
DATE OF BURIAL: Aug 31 1920

20. UNDERTAKER: Hamer B Evans
ADDRESS: Burke Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of .....

Registration District No. 39
Primary Registration District No. 2087
(No. ..... St.)

File No. 31618
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs. Marie L. E. Homling

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Married

6. DATE OF BIRTH: April (Month) 4th., (Day) 1879 (Year)

7. AGE: 41 yrs. 4 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Thomas Renne

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Anna Schnurr

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Michael Homling
(Address) Buhl, Idaho

15. Filed Aug 9 1920 J. N. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 8th., (Day) 1920 (Year) 191

17. I HEREBY CERTIFY, That I attended deceased from Aug. 8 1920, to Aug 8 — 1920 that I last saw h[illegible] alive on Aug 8 — 1920 and that death occurred on the date stated above, at 10P. M.

The CAUSE OF DEATH* was as follows:

Uremia

..... (Duration) ..... yrs. ..... mos. 1 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Bro: Jennings M. D.

Aug 9 1920 (Address) Buhl, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clover
DATE OF BURIAL: Aug. 10th 1920

20. UNDERTAKER: Homer B. Evans
ADDRESS: Buhl, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Valley
City of Cascade
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 14
Primary Registration District No.
(No. , St.)

File No. 3161
Registered No. 64
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Fred Sca

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH
(Month) (Day) 1 (Year)

7. AGE
yrs. mos. ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min.*

8. OCCUPATION
(a) Trade, professsion, or particular kind of work
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15.

Filed 8-6 1920 Mary B. McDonald Local Registrar
Dept

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191 , to 191
that I last saw h alive on 191 ,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

Acute Kidney Trouble
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs mos ds. In the State yrs mos ds.
Where was Disease contracted, If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade Ida
DATE OF BURIAL: 8-6 1920

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Valley
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 13
Primary Registration District No.

File No. 31620
Registered No. 63
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Rhoda B Carver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fm
4. COLOR OR RACE: whit
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 19 (Day) 1857 (Year)

7. AGE: 63 yrs. 11 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): not given

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): not given

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G E Hoggle
(Address) Cascade Ida

15.
Filed 191
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr 191, to 191
that I last saw h alive on 191,
and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemmorhage
(Duration) yrs. mos. ds.
Contributory (Secondary): Hyp H. Blood pressure
(Duration) yrs. mos. ds.

(Signed) G E Hoggle M. D.
19 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was Disease contracted,
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cascade Ida
DATE OF BURIAL: 7-5 1920

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 31528
Registered No. 50

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Alice Priest
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 29 (Day) 1918 (Year)

7. AGE: 2 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Russel M Priest

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Helen K Koenigs

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. R. Priest
(Address) Murphy Idaho

15. Filed August 11, 1920 W. R. Hamilton Local Registrar
M. L. R.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1920, to July 28 1920
that I last saw her alive on July 28 1920
and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis T.B.

(Duration) Yrs. mos. 21 ds.
Contributory (Secondary) Exhaustion
(Duration) yrs. mos. ds.

(Signed) Ernest O. Finney M. D.
7/29 1920 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery
DATE OF BURIAL: July 29 1920

20. UNDERTAKER: Northam McCann
ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

7

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 31623
Registered No. 57

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Laura Alice Gross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Nov (Month) 24 (Day) 1919 (Year)

7. AGE: — Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER R. H. Gross

11. BIRTHPLACE OF FATHER (State or Country) Mo

12. MAIDEN NAME OF MOTHER Isaac Brown

13. BIRTHPLACE OF MOTHER (State or Country) Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hardin Attebery
(Address) Weiser Idaho

15. Filed 8-20 1920 H. P. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 8 (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20 1920 to Aug 4 1920
that I last saw her alive on Aug 2 1920
and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:

Cardiac Embolism

..... (Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest O. Finney M. D.
8/5 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mann's Creek	8/5 1920

20. UNDERTAKER	ADDRESS
Northam & McCann	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Covert

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 31624
Registered No. 52

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary A Flood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Wht	Widowed

6. DATE OF BIRTH
May 25 1
(Month) (Day) (Year)

7. AGE
80 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. John L. Neeley
(Address) Weiser, Idaho.

15.
Filed 8-12 1920
W. P. Hamilton D.R. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August 9th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9th 1920, to Aug 9 1920 that I last saw h.er alive on Aug 9th 1920, and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:

Senile Debility

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C A Covert M. D.
8/11 1920 (Address) Weiser Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillcrest Cemetery	8-11 1920

20. UNDERTAKER Northam McCann — ADDRESS Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 31626
Registered No. 52

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ira Morton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 11 (Day) 1 (Year)

7. AGE: 24 Yrs. 8 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ky.

10. NAME OF FATHER: Robert Morton

11. BIRTHPLACE OF FATHER (State or Country): Ky

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sam D. Baker
(Address) Weiser Idaho.

15. Filed 8-20 1920
W. R. Hamilton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1920, to Aug 14 1920
that I last saw h— alive on Aug 14 1920
and that death occurred on the date stated above, at 9:10 A.M.
The CAUSE OF DEATH* was as follows:

Accidental Burn
(Flame)
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Savant M. D.
8/14 1920 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerton Cemetery — DATE OF BURIAL: 8/15 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Count

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31027

Registered No. 55

1. PLACE OF DEATH

County of Washington

City of Weiser

(No. ..... St.)

Registration District No. 86

Primary Registration District No. 2112

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Amos E. Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Wht	Widowed

6. DATE OF BIRTH: Dec (Month) 10 (Day) 861 (Year)

7. AGE: 58 Yrs. 8 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. H. Baker

(Address) Weiser Idaho

15. Filed 8-20 1920

W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1920 to Aug 13 1920 that I last saw h— alive on Aug 13 1920, and that death occurred on the date stated above, at 2.9 M.

The CAUSE OF DEATH* was as follows:

Burn accidental (flame)

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Garnant M. D.

8/14 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview Cemetery — DATE OF BURIAL: 8/15 1920

20. UNDERTAKER: Northam & McBain — ADDRESS: Weiser Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Shirley

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1017
File No. 31629
Registered No. 57

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Della May Selliger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: May (Month) 5 (Day) 1884 (Year)

7. AGE: 36 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Wm Maisenbacker

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. R. Selliger
(Address) Meisen Ida

15. Filed 8-25 1920
W. J. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1920, to Aug 27 1920, that I last saw h. alive on Aug 27 1920, and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:

Eclampsia

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Nephritis Puerperal Albuminuria
(Duration) ..... yrs. 4 mos. — ds.

(Signed) ..... M. D.
8/24 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fellcrest Cemetery — DATE OF BURIAL: 8/24 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 56
Primary Registration District No. 1010
File No. 31630
Registered No. 58

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)

2. FULL NAME Sarah Isabelle Ross

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Jan (Month) 10 (Day) 1849 (Year)

7. AGE: 71 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alabama

10. NAME OF FATHER: Albert Cole

11. BIRTHPLACE OF FATHER (State or Country): ———

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): L. E. Ross
(Address): Weiser, Idaho

15. Filed Aug 24th 1920 W. R. Hamilton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 24th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1st 1920, to Aug 24th 1920, that I last saw h.... alive on Aug 23rd 1920, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows: Chronic Valvular Heart disease

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

Aug 24 1920. (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 8/26 1920

20. UNDERTAKER: Ross Evans & Evans — ADDRESS: Weiser Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31631

Registered No. [illegible]

1. PLACE OF DEATH

County of Bingham

City of Blackfoot Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12

Primary Registration District No. 2101

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lisle Bryan Just

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	married

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1[illegible]7 (Year)

7. AGE: 23 Yrs. 9 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Porsto Idaho

10. NAME OF FATHER: James Just

11. BIRTHPLACE OF FATHER (State or Country): Blackfoot Ida

12. MAIDEN NAME OF MOTHER: Cricle Eondara Carson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Just

(Address) Shelley R 2 Idaho

15. Filed Aug 6 1920 Mrs Helen E. Palmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug July 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug July 1 1920 to July 3 1920 that I last saw h[illegible] alive on July 3 1920 and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary hemorrage

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. Mitchell M. D.

7/4 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grandview cemetery	8-6 1920

20. UNDERTAKER	ADDRESS
E. O. Peck	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31632

Registered No.

1. PLACE OF DEATH

County of Gooding

City of Gooding

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Claire McClure

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Aug 13 (Month) (Day) 1903 (Year)

7. AGE: 16 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Wm O. McClure

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary E. Brown

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Wm O. McClure

(Address): Gooding Ida.

15. Filed 8-17-1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1920, to Aug 7 1920, that I last saw h[illegible] alive on Aug 7 1920 and that death occurred on the date stated above, at 8:20 A.M.

The CAUSE OF DEATH* was as follows:

Peritonitis, following Appendicitis abscess

(Duration) Yrs. mos. 50 ds.

Contributory (Secondary)

(Duration) yrs. mos. 5 ds.

(Signed) J H Cromwell M. D.

8/7 1920 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gooding — DATE OF BURIAL: Aug 11 1920

20. UNDERTAKER: A C Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31633

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31363

Registered No. 3

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St Lukes Hospital)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter E. Parsons.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widowed)

6. DATE OF BIRTH: Aug 6 1873 (Month) (Day) (Year)

7. AGE: 47 Yrs. 1 Mos. 29 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Supervisor B & O.

(b) General nature of industry, business or establishment in which employed (or employer): A.S.L. R.R.Co.

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Nels Parsons.

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. P. E. Parsons

(Address)

15. Filed Oct 6 1920

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 5 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1920, to Oct 5 1920 that I last saw h.im alive on Oct 5 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Burns

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. E. Smith M. D.

10/6 1920 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah — DATE OF BURIAL: Oct 8 1920

20. UNDERTAKER: Summers & Kreb. — ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

31634

3168

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 1161
File No. 95
Registered No. 3411

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 821 So Fourth St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander Taylor
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH April 26th 1860
(Month) (Day) (Year)

7. AGE 40 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work City Street
(b) General nature of industry, business or establishment in which employed (or employer) Supervisor

9. BIRTHPLACE (State or Country) Salt Lake Utah

10. NAME OF FATHER William R. Taylor

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Janett Buchanan

13. BIRTHPLACE OF MOTHER (State or Country) Scotland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A. Taylor
(Address) 821 So 4th

15. Filed 9-14 1920 J.P. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1920 to Sept 12 1920
that I last saw h.. alive on Sept 12 1920
and that death occurred on the date stated above, at 1:20 P.M.
The CAUSE OF DEATH* was as follows:
Acute Gastro Enteritis
(Duration) Yrs. mos. 2 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J.P. Young M. D.
Sept 13 1920 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View | DATE OF BURIAL Sept 14 1920

20. UNDERTAKER Churchill Bros | ADDRESS Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31635
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Lund
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84
Primary Registration District No. 2161
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Schenk

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH
March 29th 1873
(Month) (Day) (Year)

7. AGE
47 Yrs. 4 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Switzerland

10. NAME OF FATHER Samuel Schenk

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Adgeline Abbersoll ✓

13. BIRTHPLACE OF MOTHER (State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martina Schenk ✓
(Address) Lund Idaho

15. Filed ..... 19.....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
August 16th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 16th 1920 to Aug. 16th 1920 that I last saw h. im alive on Aug. 16th 1920, and that death occurred on the date stated above, at 4. P. M.
The CAUSE OF DEATH* was as follows:

instantaneous death resulting from accidently coming in contact with live electric wire. (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Theo. Lindquist M. D.
8/16/1920 (Address) Bancroft Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lund Idaho ✓ DATE OF BURIAL Aug. 25th 1920 ✓

20. UNDERTAKER G. M. Lindquist ✓ ADDRESS Preston Ida. ✓

this certificate given after receiving permission from the coromor.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31636

Registration District No. .....
Primary Registration District No. .....
Registered No. .....

1. PLACE OF DEATH

County of Ada

~~City~~ or Town Eagle (No. Main Eagle St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Leroy Malone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March 6 (Month) (Day) 1917 (Year)

7. AGE: 3 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Cyrus A. Malone

11. BIRTHPLACE OF FATHER (State or Country): Wash.

12. MAIDEN NAME OF MOTHER: Lottie Haywood

13. BIRTHPLACE OF MOTHER (State or Country): Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Cyrus A Malone

(Address) .....

15. Filed Oct 1 1920 Frederic K. Towers M. D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h— alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis.

(Duration) ..... Yrs. ..... mos. 5 ds. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frederic K. Towers M. D.

..... 19..... (Address) Eagle Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/2 1920

20. UNDERTAKER: Schreiber & Sidwell — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31057

1. PLACE OF DEATH

County of Bannock

City of Bancroft

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. ..... St.)

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen L.Taylor

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: September 14th (Month) (Day) 1920. (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bancroft, Bannock county.

10. NAME OF FATHER: John D.Taylor

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Carrie J.Sorensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John D.Taylor (father).

(Address) Bancroft Idaho.

15. Filed ..... 19.....

A. C. Funkhouser
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 17th (Month) (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept.14th 19 20, to Sept.17th 19 20 that I last saw h.er alive on Sept.17th 19 20 and that death occurred on the date stated above, at 3 a M.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus,

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) asphyxia

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Geo. D. Funkhouser M. D.

9/17/1920 (Address) Bnacroft Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bancroft Idaho

DATE OF BURIAL: 9/18/20. 19.....

20. UNDERTAKER: father

ADDRESS: Bancroft Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31638

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28F
Primary Registration District No. 2464
File No. 35
Registered No. 3405

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert L Prince
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Unknown (Month) 1 (Day) (Year)

7. AGE: Unknown Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed 9-8- 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 1 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1920, to Sept 1 1920
that I last saw h— alive on Sept 1 1920
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:—
Paralysis
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. L. Wooley M. D.
Sept 1 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Fm — DATE OF BURIAL: Sept 2 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

31639

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28 B
Primary Registration District No. 2161
File No. 35
Registered No. 3406

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. W. of City St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fern O. Jefcoat

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 23 1919 (Month) (Day) (Year)

7. AGE: 1 Yrs. 5 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: J. T. Jefcoat

11. BIRTHPLACE OF FATHER (State or Country): Miss

12. MAIDEN NAME OF MOTHER: E. Collins

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. T. Jefcoat
(Address) R. R. 1 Pocatello Ida

15. Filed 9-1 1920. J. R. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1920, to Sept 1 1920, that I last saw her alive on Aug 31 1920, and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Enteritis Inanition -

(Duration) Yrs. mos. 5 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. R. Young M. D.
9/1 1920 (Address) Pocatello -

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairlawn Ida — DATE OF BURIAL: Sept 3 1920

20. UNDERTAKER: Schumacher Furn Co — ADDRESS: City

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

3164 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 784
Primary Registration District No. 2161
File No. 31
Registered No. 3407

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Lynn Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Delbert Eugine Preece

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
October 29 (Month) 29 (Day) 1905 (Year)

7. AGE
14 Yrs. 10 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At School
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Inkom Ida.

10. NAME OF FATHER J. I. Preece

11. BIRTHPLACE OF FATHER (State or Country) Franklin Ida.

12. MAIDEN NAME OF MOTHER Ella Hickman

13. BIRTHPLACE OF MOTHER (State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. I. Preece
(Address) Inkom

15. Filed 9-4 1920 J. Blouna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
September (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3rd 1920, to Sept 3rd 1920
that I last saw him alive on Sept 3rd 1920
and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
General peritonitis

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Ruptured appendix
(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) C W Lynn M. D.
Sept 4 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 7 hrs mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Inkom Ida.	Sept 5 1920
20. UNDERTAKER	**ADDRESS**
Schumacher & Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31641

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 284
Primary Registration District No. 216
File No. 35
Registered No. 3408

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. St. Anthony Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Johns, Jacob B. Bowman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec 18th 1919 (Month) (Day) (Year)

7. AGE: 0 Yrs. 8 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Martin Bowman

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Alice Sybensteyn

13. BIRTHPLACE OF MOTHER (State or Country): Holland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alice Bowman
(Address) St. Anthony Hospital

15. Filed 9/7 1920 J. R. Gowans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 5th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5-th 1920, to Sept 5 1920 that I last saw him alive on Sept 5 1920, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Hague M. D.

9.6. 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Sept 7 1920

20. UNDERTAKER: Schumacher Hall — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31642

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2-8[illegible]
Primary Registration District No. 2141
File No. 35
Registered No. 3409

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 838 E. Clark St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Birney Parsons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	white	widowed

6. DATE OF BIRTH: Dec (Month) 17 (Day) 1842 (Year)

7. AGE: 77 Yrs. 8 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real estate man
(b) General nature of industry, business or establishment in which employed (or employer): and Hdw merchant

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Nathan Parsons

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Nancy Dole

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. M. Newton
(Address) 838 E. Clark Pocatello Ida.

15. Filed Sept 13 1920 J. P. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 10 1919 to Sept 10 1920 that I last saw him alive on Sept 10 1920 and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Exhaustion, uremic Coma

(Duration) ..... Yrs. * mos. 4 ds.

Contributory (Secondary): Prostatic Hypertrophy

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) W. J. Howard M. D.

9/13 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. ..... mos. ..... days. In the State 7 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Dwight Illinois

19. PLACE OF BURIAL OR REMOVAL: Dwight. Ill. DATE OF BURIAL: Sept 13 1920

20. UNDERTAKER: H. L. McHAN ADDRESS: POCATELLO. IDAHO

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH 31643

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 284 — File No. 35

City of Pocatello — Primary Registration District No. 2161 — Registered No. 3409

(No.) St. Anthony's Hospital (St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Granger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH — Exact date unknown — 1859
(Month) (Day) (Year)

7. AGE — 61 Yrs. Mos. ds. — Near as known — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Common Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER — Granger

11. BIRTHPLACE OF FATHER (State or Country) unknown

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred P. Masoner
(Address) 111 N. 16th St Boise Ida

15. Filed 9/13 1920 — H. R. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Sept 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1920 to Sept 12 1920, that I last saw him alive on Sept 12 1920, and that death occurred on the date stated above, at 9:00 A.M.

The CAUSE OF DEATH* was as follows:
Accident - Runaway team - fracture ribs - Lacerated Scalp - internal injuries
(Duration) Yrs. mos. 5 ds.
Contributory (Secondary) Internal hemorrhage - Hypostatic congestion - All things
(Duration) yrs. mos. 5 ds.

(Signed) Hamner Owen M. D.
9/13 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL — Boise Idaho — DATE OF BURIAL 9/14 1920

20. UNDERTAKER — Schumacher & Hagerman — ADDRESS Pocatello

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—35 M. 1-29.

Dr. Lynn 31644

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2961
File No. 35
Registered No. 410

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Lynn Bros Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Chevelier
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Female / Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Sept (Month) 7 (Day) 1892 (Year)

7. AGE: 28 Yrs. 0 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Dining car waiter
(b) General nature of industry, business or establishment in which employed (or employer): Employee

9. BIRTHPLACE (State or Country): Lausanne

10. NAME OF FATHER: Louis chevelier

11. BIRTHPLACE OF FATHER (State or Country): France

12. MAIDEN NAME OF MOTHER: Alice Cavlier

13. BIRTHPLACE OF MOTHER (State or Country): Lausana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Geo Chevelier
(Address) Pocatello Idaho

15. Filed 9/14 1920 — J. H. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1920, to Sept 7 1920
that I last saw h. alive on Sept 7 1920
and that death occurred on the date stated above, at 9.15 P.M.
The CAUSE OF DEATH* was as follows:
Basal Skull Fracture

(Duration) — Yrs. — mos. 2 ds.
Contributory (Secondary) Internal injuries
(Duration) — yrs. — mos. 2 ds.

(Signed) J. H. Young M. D.
Sept 13 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death — yrs. — mos. — days. In the State ..... yrs. ..... mos. 2 days
Where was disease contracted if not at place of death? accidental
Former or usual residence 407 No 4th Pocatello

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Sept 14th 1920

20. UNDERTAKER: Schumacher Bros — ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31645

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2141
File No. 33
Registered No. 3412

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 1005 Prague St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah L. Hoffman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH June 17 1849
(Month) (Day) (Year)

7. AGE 71 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Harris Gilbert

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Clark

13. BIRTHPLACE OF MOTHER (State or Country) Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. V. T. Rowell
(Address) Pocatello

15. Filed 9/15 1920

J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 6 1920 to Sept 13 1920 that I last saw her alive on Sept 13 1920, and that death occurred on the date stated above, at 11:2a M.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneracy
Chr. Myocarditis.

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. K. Lyon M. D.
Sept 14 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kansas Idaho	9/15 1920

20. UNDERTAKER W. H. Walker ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

City of Pocatello (No. Rauch & Pullous St.) Registered No. 3413

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Hayes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: About 1881 (Month) (Day) (Year)

7. AGE: About 39 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Henry Hayes

11. BIRTHPLACE OF FATHER (State or Country): Andreastown N.Y.

12. MAIDEN NAME OF MOTHER: Cathleen Hazelline

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs David Hayes
(Address) Pocatello

15. Filed 9/15 1920 J.P. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12, 1920, to Sept 12, 1920, that I last saw him alive on Sept 10 1920, and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:
Chronic bright's disease

(Duration) 1 Yrs. 3 mos. ds.
Contributory (Secondary) Broken compensation of heart
(Duration) yrs. 2 mos. ds.

(Signed) A.M. Newton M. D.
Sept 13 1920 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery | DATE OF BURIAL: 9/15 1920

20. UNDERTAKER: H.O. Walker ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

FORM V. S. No. 5-25 M. 1-19-18

CERTIFICATE OF DEATH.

31647

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 2161

File No. 35

Registered No. 3414

1. PLACE OF DEATH.

County of Bannock

City of Pocatello

(No.) Lynn Bros. St.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Boy Leslie Nell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Sept (Month) 15 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many — hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Infant

(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Lynn Bros Hospital Bannock Co. Pocatello Ida

10. NAME OF FATHER Leslie Nell

11. BIRTHPLACE OF FATHER St. Charles Idaho (State or Country) Bear Lake

12. MAIDEN NAME OF MOTHER Vivian Pugmire

13. BIRTHPLACE OF MOTHER St. Charles Idaho (State or Country) Bear Lake

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. N. Lynn

(Address) 446 S. Main Ave

15.

Filed 9-16 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1920, to Sept 15 1920, that I last saw h— alive on Sept 15 1920, and that death occured on the date stated above, at 3.20 P M.

The CAUSE OF DEATH* was as follows:

Premature Birth

Possibly Five Months

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) J. N. Lynn M. D.

Sept 15 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? Premature Birth

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: 9/16 1920

20. UNDERTAKER: H. B. Walker — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13 (Green)

CERTIFICATE OF DEATH.

31648

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28

Primary Registration District No. 2191

File No. 35

Registered No. 315

1. PLACE OF DEATH

County of Bannock

City of Pocatello Ida

(No. Lynn Ave North St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Leslie Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. Sept (Month) 15 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ... hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): premature

9. BIRTHPLACE (State or Country) Pocatello Idaho / Bannock

10. NAME OF FATHER Leslie Hill

11. BIRTHPLACE OF FATHER (State or Country) St Charles Idaho / Bear Lake

12. MAIDEN NAME OF MOTHER Vivian Pugmire

13. BIRTHPLACE OF MOTHER (State or Country) St. Charles Ida / Bear Lake

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. H. Hill

(Address) 440 W Kay ave

15. Pocatello Idaho Sept 15 1920

Filed 9-16 1920

Reg. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from sept 15 1920, to sept 15 1920, that I last saw him alive on sept 15 1920 and that death occured on the date stated above, at 3.30 P.M.

The CAUSE OF DEATH* was as follows:

premature Birth,
Possibly fire Burns.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....

(Duration ... yrs. ... mos. ... ds.

(Signed) J. H. Hill M. D.

sept 15 1920 (Address) Pocatello Ida

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? premature Birth

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery — DATE OF BURIAL: 9/16, 1920

20. UNDERTAKER: J. M. Wooster — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 24652

FORM V. S. No. 5-A—25 M. 1-19.

31650

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 36
Registered No. 3417

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 522 — N. Garfield St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jean B Nichols
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: May (Month) 27 (Day) 1920 (Year)

7. AGE: Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Bert Nichols

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ada Corbridge

13. BIRTHPLACE OF MOTHER (State or Country): Pocatello Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bert Nichols
(Address) 522 - N Garfield

15. Filed 9 18 1920 — J. R. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1920 to Sept 18 1920
that I last saw ~~him~~ alive on Sept 18 1920 at 12 midnight
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Acute gastro enteritis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Young M. D.
9/18/19-20 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem — DATE OF BURIAL: 9-18 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31651

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. '28
Primary Registration District No. 2161
File No. 36
Registered No. 3418

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 901 Wayne Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Goodenough
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June 19 (Month) (Day) 1870 (Year)

7. AGE: 50 Yrs. 3 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: Andrew Goodenough

11. BIRTHPLACE OF FATHER (State or Country): Michigan

12. MAIDEN NAME OF MOTHER: Mary E Bell

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Will Goodenough
(Address) McCammon

15. Filed 9/23 1920 J. H. Gaines Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 22 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1920 to Sept 22 1920 that I last saw him alive on Sept 22 1920 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Acute gastritis
(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) W. W. Brothers M. D.
Sept 23 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: McCammon Idaho
DATE OF BURIAL: 9-24-1920

20. UNDERTAKER: Schumacher & Hull
ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-26 M. 1-19.

CERTIFICATE OF DEATH

31652

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 21/1
File No. 34
Registered No. 3419

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. 628 So 8th St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christine Marie Lorenzen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Feb (Month) 3 (Day) 1839 (Year)

7. AGE: 81 Yrs. 6 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Schleswig Denmark

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Helene Gerhardt
(Address) Pocatello

15. Filed 9-23 1920 J. H. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1920, to Sept 22 1920
that I last saw h.er alive on Sept 22 1920
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Senility
(Duration) Yrs. Senal mos. ds.
Contributory (Secondary) Hypostatic pneumonia
(Duration) yrs. mos. 3 ds.

(Signed) A M Newton M. D.
Sept 23 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt. Laurel Cem. | DATE OF BURIAL: 9/24 1920

20. UNDERTAKER: H. H. Foster | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31653

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

File No. 36

County of Bannock.

City of Pocatello. (No. ..... St.)

Registered No. 3421

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elinor Tressa Kockling

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 27 (Day) 1920 (Year)

7. AGE: 0 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: Joseph Kockling

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: May Gibson.

13. BIRTHPLACE OF MOTHER (State or Country): Nevada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joseph Kockling

(Address) 208 So 12 Ave.

15. Filed 9-24 1920

J. H. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1920, to Sept 22 1920, that I last saw h er alive on Sept 22 1920, and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute enteritis

..... (Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) asm Newton M. D.

Sept 23 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 7 mos. 27 days. In the State ..... yrs. life mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence 208 So 12 Ave.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: 9/25 1920

20. UNDERTAKER: H. L. McHan. ADDRESS: 215 S. Main Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31654

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 34
Registered No. 3421

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. [illegible] St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A. S. Dest

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 15th (Day) 1844 (Year)

7. AGE: 76 Yrs. 4 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: /

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. McNeil
(Address) 1611 Roosevelt

15.
Filed 9-29 1920
J. P. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1920 to Sept 26 1920, that I last saw h[illegible] alive on Sept 26 1920, and that death occurred on the date stated above, at 1:30 M.

The CAUSE OF DEATH* was as follows:
Pneumonia (Primary)
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Ira McNamee M. D.
Sept 27 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
I. O. O. F. cemetery	9-28 1920

20. UNDERTAKER: [illegible] Walker
ADDRESS: Pocatello Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31655

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36

Registered No. 3422

1. PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 216

(No. 1220 North Main St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Carrow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: Sept (Month) 14 (Day) 1918 (Year)

7. AGE: 2 Yrs. — Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida

10. NAME OF FATHER: John Carrow

11. BIRTHPLACE OF FATHER (State or Country): Italy

12. MAIDEN NAME OF MOTHER: Anna Marostica

13. BIRTHPLACE OF MOTHER (State or Country): Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Carrow

(Address) 723 No 8th

15. Filed 9-27 1920

J. H. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1920, to Sept 27 1920, that I last saw her alive on Sept 27 1920, and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Myocarditis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Lynn M. D.

Sept 27 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello Cemetery	9/28 1920

20. UNDERTAKER: A. L. Walker ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31656

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 36
Registered No. 3423

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 357 S. Main St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George J. Binnais
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Buck
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug 11 (Month) 1 (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: \
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Gus Binnais

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Edwita McCreary

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gus Binnais
(Address) 357 S. Main

15. Filed 9-28 1920 J. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1920 to Sept 28 1920
that I last saw h... alive on Sept 27 1920
and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:
Acute coecal
Enteritis
(Duration) ..... Yrs. ..... mos. 2 or 3 ds.
Contributory (Secondary) Intolerance to sugars having been fed on Eagle Brand food.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Young M. D.
Sept 28 1920 (Address) Pocatello, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello DATE OF BURIAL: Sept 29 1920

20. UNDERTAKER: Shumacher & Hay ADDRESS: Pocatello Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53
Primary Registration District No. 2132.
File No. 31657
Registered No.

1. PLACE OF DEATH
County of Bear Lake.
City of Liberty
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jasper Poulsen.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 28 (Day) 1831 (Year)

7. AGE: 89 Yrs. 11 Mos. 5 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known.

13. BIRTHPLACE OF MOTHER (State or Country): Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15.
Filed 19
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 3. (Day) 1920 (Year),

17. I HEREBY CERTIFY, That I attended deceased from 19, to 19,
that I last saw h alive on 19,
and that death occurred on the date stated above, at M.
The CAUSE OF DEATH* was as follows:

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) James J. Parker M. D.
Sept 3 1920 (Address) Paris Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL 19
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 33
Primary Registration District No. 2132
File No. 31658
Registered No.

1. PLACE OF DEATH
County of Bear Lake.
City of Paris.
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adam Seegmiller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: June (Month) 29 (Day) 1889 (Year)

7. AGE: 81 Yrs. 3 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer): Farmer.

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Adam Seegmiller.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Anna Eva Knechtel.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Seegmiller
(Address) Paris Ida.

15. Filed 10/20/20 19 — J. A. Sutton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1920 to Oct. 16 1920
that I last saw h[illegible] alive on Oct 16 1920
and that death occurred on the date stated above, at 5:20 A.M.
The CAUSE OF DEATH* was as follows:
Hemoplegia.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. A. Sutton M. D.
10/6 1920 (Address) Paris

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris | DATE OF BURIAL: 10/18 1920

20. UNDERTAKER: Bishop Stucki | ADDRESS: Paris

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 6-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31659
Registered No.

1. PLACE OF DEATH
County of Bear Lake.
City of Paris.
(No. ....., ... St.)
Registration District No. .....
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wallace Orvil Thurston.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1883 (Year)

7. AGE: 37 Yrs. ..... Mos. 21 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah.

10. NAME OF FATHER: Joseph W^m Thurston

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Kate Williams.

13. BIRTHPLACE OF MOTHER (State or Country): Provo Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rose Thurston
(Address) Paris.

15. Filed 9/25/20 19..... R. J. Sutton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1920 to Sept. 25 1920, that I last saw h^m alive on Sept 25 1920 and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Hypostatic pneumonia from stoppage of bowels & liver.
Spells (Duration) 20 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Ulcer known, Ulcer of duodenum
(Duration) ..... yrs. ..... mos. 2 5 ds.
(Signed) R. J. Sutton M. D.
9/28/20 (Address) Paris

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Paris.

19. PLACE OF BURIAL OR REMOVAL: Paris. DATE OF BURIAL: 9/28/20

20. UNDERTAKER: Fisher & Low ADDRESS: Paris.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31660

Registered No. 46

1. PLACE OF DEATH

County of Benewah

City of St. Maries

(No. ....., ... St.)

Registration District No. 32

Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Owen Maguire

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH January 23 1833
(Month) (Day) (Year)

7. AGE 87 Yrs. 8 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Lagrange Co. Ind.

10. NAME OF FATHER Lindsey Maguire

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. E. McMillan

(Address) 134 3rd St. St Maries

15. Filed Sept. 27 1920 H E Hunt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. 26 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920 to Sept 26 1920, that I last saw him alive on Sept 1 1920, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

..... (Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Gen exhaustion

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas W Platt M. D.

Sept 26 1920 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	9/8 1920
20. UNDERTAKER	**ADDRESS**
H Edmunds Co	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31661

1. PLACE OF DEATH
County of Lemhi
City of St Maries
(No. ..... St.)
Registration District No. 32
Primary Registration District No. 2049
Registered No. 45
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Evelyn Jewett
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 30 (Day) 1917 (Year)

7. AGE: 2 Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: -
(b) General nature of industry, business or establishment in which employed (or employer): -

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edward E. Jewett

11. BIRTHPLACE OF FATHER (State or Country): California

12. MAIDEN NAME OF MOTHER: Bertie Margaret Mungle

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward E. Jewett
(Address) Tolo Ida.

15. Filed Sept. 15 1920 H. E. Hunt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13 1920 to Sept 13 1920 that I last saw her alive on Sept. 13 1920 and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) - Yrs. mos. 2 ds.
Contributory (Secondary) Stomach and Bowel trouble
(Duration) yrs. mos. 2 ds.

(Signed) Owen D. Pollatt M. D.
Sept 13 1920 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: Woodlawn — DATE OF BURIAL: 9-15 1920

20. UNDERTAKER: Mitchell & Meagher — ADDRESS: St Maries Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 31662
Registered No. 44

1. PLACE OF DEATH
County of Benewah
City of St Maries, Ida. (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lyman F. Green
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~single, married~~ widowed

6. DATE OF BIRTH: Dec (Month) 10 (Day) 1837 (Year)

7. AGE: 82 Yrs. 8 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Engineer
(b) General nature of industry, business or establishment in which employed (or employer): member G. A. R.

9. BIRTHPLACE (State or Country): Lowell, Mass.

10. NAME OF FATHER: Amas Green

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Hospital Record
(Address) St. Maries Ida.

15. Filed Sept. 6 1920 H. E. Grant Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1919, to Sept 2 1920
that I last saw h~~im~~ alive on Sept 1 1920
and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Coronoma of Stomach
(Duration) Yrs. 5 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Chas E Pratt M. D.
Sept 2 1920 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodlawn | DATE OF BURIAL 19

20. UNDERTAKER: Mitchell & Meagher | ADDRESS St Maries

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 31063
Registered No. 43

1. PLACE OF DEATH
County of Benewah
City of St. Maries
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dessie Myrtle Marks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fe M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March 22 1894 (Month) (Day) (Year)

7. AGE: 26 Yrs. 5 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: William E. Lewis

11. BIRTHPLACE OF FATHER (State or Country): Wis.

12. MAIDEN NAME OF MOTHER: Della May Light

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs H. A. Mutch
(Address) St. Maries

15. Filed Sept 1 1920 — H. E. Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1920, to Sept. 1 1920, that I last saw her alive on Sept 1 1920, and that death occurred on the date stated above, at 2 A M.
The CAUSE OF DEATH* was as follows:

Septicaemia

..... (Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary): Abortion
..... (Duration) ..... yrs. 1 mos. 7 ds.

(Signed) Owen O Plaid M. D.
Sept 1 1920 (Address) St Maries Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL 1920

20. UNDERTAKER: H E Hunt Co — ADDRESS St. Maries Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 116

Primary Registration District No. 285

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31664

Registered No. 35

1. PLACE OF DEATH.

County of Bingham

City of ~~Blackfoot~~ Springfield (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geraldine Blackburn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 5 (Day) 1920 (Year)

7. AGE ..... Yrs. 1 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Dewey Earl Blackburn

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Vahre Ellen Keetley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Dewey Blackburn

(Address) Springfield Ida

15. Filed 9/9 191 D McCampbell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 20 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Sept 9 1920, that I last saw h[illegible] alive on Sept 8 1920 and that death occured on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:

Scalp injuries at birth

(Duration) Yrs. 1 mos. 4 ds.

Contributory (Secondary): Empiema

(Duration yrs. mos. 10 ds.

(Signed) W McCampbell M. D.

9/9 1920 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Springfield Ida — DATE OF BURIAL: 9/10 191[illegible]

20. UNDERTAKER: Friend — ADDRESS

SYMS - YORK CO., PTRS. & STRS. 24953

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

7/16 31665

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3

Registered No. 36

1. PLACE OF DEATH.

County of Bingham

City of Aberdeen

Registration District No.

Primary Registration District No. 2155

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Grace Emma Courtney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 13 (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Emmet Courtney

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Emma Cloud

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Grace Courtney

(Address) Aberdeen Ida

15. Filed Sept 13 20 memorkinney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 12 (Day) 20 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1920 to Sept 12 1920, that I last saw h[illegible] alive on Sept 12 1920, and that death occured on the date stated above, at 8 45 P.M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ..... Yrs. ..... mos. 25 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. C. Mortensen M. D.

9/13 1920 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL I.O.O.F. Cemetery Aberdeen Ida — DATE OF BURIAL 9/13 1920

20. UNDERTAKER Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 1007.

(No. Gen. Hospital St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31666

Registered No. 95

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Roy Bud Hardy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Aug 29 ~~30~~ 1920 (Month) (Day) (Year)

7. AGE: 1 Yrs. 1 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot

10. NAME OF FATHER: Russell D Hardy

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Elsie Jane Harrison

13. BIRTHPLACE OF MOTHER (State or Country): Texas Oklahoma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. D Hardy
(Address) Blackfoot

15. Filed Sept. 3 1920 M. N. E. Palmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7 20 A M.
The CAUSE OF DEATH* was as follows: Premature birth
4 hrs 20 mo

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. E. Patrie M. D.

Sept 3 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 5 days. In the State ..... yrs. ..... mos. 5 days
Where was disease contracted if not at place of death? -
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grove City Cemetery	Sept 3 1920

20. UNDERTAKER	ADDRESS
Ed L Egli	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31007

Registered No. 96

1. **PLACE OF DEATH**

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12

Primary Registration District No. 10

(No. Cor of Lincoln & Birch St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rascoe Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 30 (Day) 1920 (Year)

7. AGE: Yrs. 3 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W R. Roberts

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Nellie Murphy

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W R Roberts

(Address) Blackfoot

15. Filed Sept 4 19 20 Mrs Nellie E. Fabrick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Sept 4 1920, to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ..... Yrs. 4 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O. Humphrey M. D.

9/4 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverside Cemetery — DATE OF BURIAL: 9/5 1920

20. UNDERTAKER: E J Funk — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1087
File No. 31068
Registered No. 97

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. Ma Cook St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Pratt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Nov. 20 1868 (Month) (Day) (Year)

7. AGE: 51 Yrs. 9 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer (Retired)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales - England

10. NAME OF FATHER: Joseph Pratt

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Sarah Ann Gale

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wilson Pratt
(Address) Shelley Ida Route 2

15. Filed Sept 6 1920 Mo Nalen E. Patrie Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 5 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2, 1920 to Sept 5 1920 that I last saw him alive on Sept 5 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Anaemia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. E. Patrie M. D.

Sept 6 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cem. DATE OF BURIAL: Sept 7 1920

20. UNDERTAKER: E. J. Peck ADDRESS: Blkfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... , ... St.)

File No. 31669
Registered No. 98

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Sylvester Merrill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
M.	W.	Married

6. DATE OF BIRTH
Aug 4th 1888
(Month) (Day) (Year)

7. AGE
32 Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Joseph Merrill

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Martha A. Compton

13. BIRTHPLACE OF MOTHER (State or Country) [illegible]

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edwards M Merrill
(Address) Box 714 Blackfoot

15. Filed Sept 6th 1920 Mattie E. Pate
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept 6th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5, 1920, to Sept 6 1920
that I last saw him alive on Sept 5 1920,
and that death occurred on the date stated above, at 1:55 P.M.
The CAUSE OF DEATH* was as follows: Hemorrhage of lungs-Tuberculosis

(Duration) Yrs. 1 mos. 15 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. E. Petrie M. D.
19..... (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Riverside Cem	19.....

20. UNDERTAKER	ADDRESS
Ed L. Eggli	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31670

Registered No. 94

1. PLACE OF DEATH

County of Bingham

City of Groveland.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Adam Yancey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 6 (Day) 1859 (Year)

7. AGE: 61 Yrs. 4 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bountiful Utah

10. NAME OF FATHER: Hyrum Yancey

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Harriet Wood

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emerson Yancey

(Address) Groveland

15. Filed Sept. 16 1920 Mrs Nalie E. Price Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 8. 1919, to Sept 15 1920

that I last saw him alive on Sept 15 1920

and that death occurred on the date stated above, at 5-05 A M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) 1 Yrs. ~ mos. ~ ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. W. McDonald M. D.

9/15 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Groveland Cemetery

DATE OF BURIAL: Sept 17 1920

20. UNDERTAKER: E. L. Eglin

ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5. 12½ M. 7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 31672
Registered No. 101

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. ..., Gabardi St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leopold Gabardi

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Oct (Month) 14 (Day) 1869 (Year)
7. AGE: 50 yrs. 11 mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Rancher
(b) General nature of industry business or establishment in which employed (or employer): ...
9. BIRTHPLACE (State or Country): Austria
10. NAME OF FATHER: Laurence Gabardi
11. BIRTHPLACE OF FATHER (State or Country): Austria
12. MAIDEN NAME OF MOTHER: Madalina Martini
13. BIRTHPLACE OF MOTHER (State or Country): Austria
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Angelina Gabardi
(Address) Rupert, Ida
15. Filed Sept. 17 1912 Mrs Nalen E. Pabst Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 15 (Day) 1912 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1912, to Sept 15 1912 that I last saw h[illegible] alive on Sept 14 1912 and that death occurred on the date stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:
Conflagration of Pyrochosis
Epilepsy

(Duration) yrs. 3 mos. 15 ds.
Contributory (Secondary) Acute Pyrochosis and auto infection
(Duration) yrs. 3 mos. 25 ds.

(Signed) C. A. Jones M.D.
9/16 1912 (Address) Blackfoot, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place State Asylum In the Blackfoot, Ida
of death ... yrs. 3 mos. 15 ds. State ... yrs. ... mos. ... ds.
Where was disease contracted, if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: [illegible] DATE OF BURIAL: ... 191...

20. UNDERTAKER: E. J. Rank ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 31674
Registered No. 103

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Viola Christina Vollmeiler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 10 (Day) 1920 (Year)

7. AGE: ... Yrs. 6 Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Henry A. Vollmeiler

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Justena Meier

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry A. Vollmeiler
(Address) Blackfoot Idaho

15. Filed Sept ... 19... Mrs Nulen E. Patrick
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1920, to Sept 16 1920 that I last saw her alive on Sept 14 1920 and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:
Food intoxication
(Bottle feed)
(Duration) 1 Yrs. ... mos. 6 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) W W Beck M. D.
9/16 1920 (Address) Blackfoot, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rest American Falls | DATE OF BURIAL ... 19...

20. UNDERTAKER: E J Peck | ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 31675
Registered No. 104

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. 640, Summit St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rufus Gordon Bills

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married
6. DATE OF BIRTH: March (Month) 25 (Day) 1892 (Year)
7. AGE: 28 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Automobile Dealer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Manassa, Colo
10. NAME OF FATHER: William Andrew Bills
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Henrietta Vell
13. BIRTHPLACE OF MOTHER (State or Country): Ill.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Irene E. Bills
(Address) Blackfoot Idaho
15. Filed Sept 21 1920 Mona Nalen E. Pabst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased ~~from~~ on Sept 17 1920 to ..... 19..... that I last saw h.... alive on Sept 17 1920 and that death occurred on the date stated above, at 5.32 P.M.
The CAUSE OF DEATH* was as follows:
Automobile accident
Crushed Breast & Temple
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J O Hamilton M. D.
9/21/1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferm City Cemetery — DATE OF BURIAL: 9-23 1920
20. UNDERTAKER: E J Peck — ADDRESS: Blackfoot

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 31676
Registered No. 103

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Keith Robert Edwards
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: November (Month) 25 (Day) 1920 (Year)

7. AGE: ... Yrs. 9 Mos. 25 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jonathan Edwards

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Annie Barnard

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Blackfoot Ida
(Address) Jonathan Edwards

15. Filed Sept 20 1920 Mrs Nadeen E. Pobee
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1920, to Sept 19 1920
that I last saw him alive on Sept 18 1920
and that death occurred on the date stated above, at 5:20 P.M.
The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration) ... Yrs. ... mos. 11 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) W A Beck M. D.
Sept 20 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery | DATE OF BURIAL ... 19...

20. UNDERTAKER: Jonathan Edwards | ADDRESS

MAY 2 0 1975

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2144
File No. 31677
Registered No. 106

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

(No. [illegible] St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnerva Booth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: 7 (Month) 20 (Day) 1889 (Year)

7. AGE: 31 Yrs. 6 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bear Lake Co. Idaho

10. NAME OF FATHER: Wm Findlay

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Agnes Howell

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Magnus Perkins
(Address) Blackfoot, Ida

15. Filed Sept. 20 1920 Mrs Nulen E. Watts Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1919 to Sept 1920
that I last saw her alive on Aug 1920
and that death occurred on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows:
Sepsis & Diarrhea

(Duration) ..... Yrs. 6 mos. 0 ds.
Contributory (Secondary) Cancer of bowels and Recto vaginal wall
(Duration) 1 Yrs. 6 mos. ..... ds.

(Signed) E. A. Cooper M. D.
9-20-1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris Idaho
DATE OF BURIAL: 19

20. UNDERTAKER: E. Peck
ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 31678
Registered No. 107

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. 81, No Commercial St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Jan. (Month) 30 (Day) 1848 (Year)

7. AGE: 72 Yrs. 7 Mos. 27 ds.
If LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Ole Soulby

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Dont Know,

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mabel E. Johnson
(Address)

15. Filed Sept 28 1920 Mrs Mabel E. Petrie
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated
Dec 19..., to ... 19...,
~~that I last saw h... alive on...~~ 19...,
and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Disease Heart
& old age

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Bright's Disease
(Duration) 3 yrs. ... mos. ... ds.

(Signed) ~~The~~ Mabel E. Petrie M. D.
Sept 30 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] | DATE OF BURIAL: Sept 30 1920

20. UNDERTAKER: [illegible] | ADDRESS: [illegible]

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 2-A—25 M. 7-18.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 121

Primary Registration District No. 209

File No. 31529

County of Bingham

City of Blackfoot (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edna Donell Jewett

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May 23 (Month) (Day) 1920 (Year)

7. AGE: Yrs. 4 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Blackfoot Idaho

10. NAME OF FATHER: Earl Jewett

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Edna Hatch

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edna H. Jewett

(Address) Blackfoot Ida

15.

Filed Oct 1 1920 Mrs Nate E. Price Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 30 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to Sept 30 1920

that I last saw h.er alive on Sept 1 1920

and that death occurred on the date stated above, at 11 25 a M.

The CAUSE OF DEATH* was as follows:

Diarrhoea and Enteritis

.....

.....

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs.....mos.....ds.

(Signed) H. Simmons M. D.

9/ 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverland Cemetery — DATE OF BURIAL: Oct 1 1920

20. UNDERTAKER: Ed L Eglin — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2022
(No. ....., ... St.)

File No. 31680
Registered No. 37

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Blaine.
City of Bellevue.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl V. Garside.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.
6. DATE OF BIRTH. July 4th 1892. (Month) (Day) (Year)
7. AGE: 28 Yrs. 2 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Utah.
10. NAME OF FATHER: Aaron Garside.
11. BIRTHPLACE OF FATHER (State or Country): England.
12. MAIDEN NAME OF MOTHER: e
13. BIRTHPLACE OF MOTHER (State or Country): e
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. E. V. Garside
(Address) Bellevue, Ida.
15. Filed 9-10 1920 R. A. Wright Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 5th 1920. (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 19th 1920, to Sept 4th 1920, that I last saw h[illegible] alive on Sept 4th 1920, and that death occured on the date stated above, at 9 a M.
The CAUSE OF DEATH* was as follows:
Pulmonary Embolism
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary): Pneumonia
(Duration) — yrs. — mos. — ds.
(Signed) R. A. Wright M. D.
Sept 6th 1920. (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City, Utah. DATE OF BURIAL: ✓ 191
20. UNDERTAKER: R. D. Harris. ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 57

Primary Registration District No. 2022

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31681

Registered No.

1. PLACE OF DEATH.

County of Blaine

City of Gannett

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles E. Hudson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug. (Month) 14 (Day) 1863 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana.

10. NAME OF FATHER: Levi Hudson.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur L. Hudson

(Address) Gannett

15. Filed 9-20 1920. R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

Wright.

16. DATE OF DEATH Sept. 19 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 14 1920 to Sept. 19 1920 that I last saw him alive on Sept. 19 1920 and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.

9/20 1920 (Address) Hailey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey, Ida — DATE OF BURIAL: 9-21 1920

20. UNDERTAKER: R. D. Harris — ADDRESS: Hailey

BYNS - YORK CO., PTRS. & BDRS. 24653

Alex 71

Form 860—5-M-4-19

SPOKANE HEALTH DEPARTMENT AND BUREAU OF VITAL STATISTICS

City of Spokane
Registration District No. 2

DEATH CERTIFICATE

Record No. 31682

1. PLACE OF DEATH No. N. P. Train St. Registered No. 1357
(If death occurred in a hospital or institution, give its name instead of St. and No.)

2. FULL NAME Mrs. Mary A Moore

(a) Residence No. Lincoln Nebraska St.; Section of Spokane—East; West; North; South; (Encircle Section)
(Usual place of abode)

(b) If non-resident, give city or town, and state Lincoln Nebraska

(c) How long in Spokane X yrs. X mos. ds.; how long in U. S. if of foreign birth yrs. mos. ds.

Personal and Statistical Particulars.

3. Sex	4. Color or Race	5. Single, Married, Widowed or Divorced (write the word)
Female	White	Widowed

5. (a) If married, widowed, or divorced
Husband of
or
Wife of

6. Date of birth: May (Month) 11 (Day) 1849 (Year)

7. Age: 71 yrs 6 mos 21 ds. If less than one day: hrs. or min.

8. Occupation of deceased:
(a) Trade, profession, or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): Retired
(c) Name of employer:

9. Birthplace (City or Town)
(State or country): Penn.

PARENTS

10. Name of Father: Gaillet. Trafts.
11. Birthplace of Father (City or Town) (State or Country): Penn.
12. Maiden name of Mother: Marguite Waidow
(City or Town)
(State or Country): Penn

14. Informant: Mrs Jno Stutchison
Address: Tacoma R 2 Box 3

15. Filed Oct. 9, 1920: By Alex Trembel Deputy. Registrar

Medical Certificate of Death.

16. Date of death: Oct. (Month) 8 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..., 19..., to ..., 19...,
that I last saw h... alive on ..., 19...,
and that death occurred on the date stated above, at ... m.
(State the Disease causing Death, or, in deaths from Violent causes, state: (1) Means and nature of Injury; and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL)
The CAUSE OF DEATH was as follows:

Apoplexy.

(Duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY
(Secondary)
(Duration) ... yrs. ... mos. ... ds.

18. Where was disease contracted if not at the place of death?
(a) Did an operation precede death? No Date of
(b) Was there an autopsy? Yes
(c) What test confirmed diagnosis? Autopsy findings

(Signed) W. M. Newman M. D.
10/9 1920 Address Coroner

19. Place of Burial, Cremation or Removal: Lincoln Neb. Date of Burial: Oct 10 19...

20. Undertaker: Shepard & Hard Address: 427-4th

I HEREBY CERTIFY, That I have been unable to secure answers to questions 5
(Insert numbers of unanswered questions)

Edward M. Shepard
(Signature of Undertaker)

Coroner's Case

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31683
Registered No.

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 2933

(No. Sandpoint St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry Russel Pinkerton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: June 5 (Month) (Day) 1920 (Year)

7. AGE: Yrs. 3 Mos. 12 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: c

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm J. Pinkerton

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Augusta Wilson

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Augusta Pinkerton

(Address) Sandpoint

15. Filed Oct 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Mal Nutrition

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. R. Wallentine M. D.

9-17 1920 (Address) Sandpoint Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint Ida — DATE OF BURIAL: Sept 17, 1920

20. UNDERTAKER: O. H. Finch. — ADDRESS: Sandpoint Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31684

Registration District No. 18
Primary Registration District No. 2183-

1. PLACE OF DEATH

County of Bonner

City of Sandpoint, Ida. (No. City Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs Ida Williams.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married.

6. DATE OF BIRTH: Sept. (Month) 15, (Day) 1889 (Year)

7. AGE: 31 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country): So. Dok.

10. NAME OF FATHER: Daniel Bittner.

11. BIRTHPLACE OF FATHER (State or Country): Russia.

12. MAIDEN NAME OF MOTHER: Eva Seiler.

13. BIRTHPLACE OF MOTHER (State or Country): Russia.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Will Williams.
(Address) Algoma, Ida.

15. Filed Oct 8 19 20 FLOYD G. WENDLE Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 28 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27. 1920. to Sept 28 1920
that I last saw h..er.. alive on Sept 28 1920.,
and that death occurred on the date stated above, at 11A.M.
The CAUSE OF DEATH* was as follows:

Shock, Operation, pelvic abscess

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) C. P. Haverland M. D.

Oct. 5 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Oct. 2, 1920.

20. UNDERTAKER: B.W.Pugh. ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 31685
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint.
(No. City Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Anna Molke.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: Sept. 2, 1852.
(Month) (Day) (Year)

7. AGE: 69 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Bro Gensen.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Margurite Carson.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Molke.
(Address) Athol, Ida.

15. Filed Oct 8 1920

FLOYD G. WENDLE
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 27 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 22 1920, to Sept. 27 1920, that I last saw h... alive on Sept. 27 1920, and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Cancer of uterus

(Duration) Unknown yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) O F Payne M. D.
Oct. 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Athol, Ida. DATE OF BURIAL: Sept. 29, 1920.

20. UNDERTAKER: B. W. Pugh. ADDRESS: Sandpoint, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31686

Registration District No. 78
Primary Registration District No. 2 0 5
(No. [illegible] Hayden St.)
Registered No.

1. PLACE OF DEATH
County of Bonner
City of Kootenai
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adeline Emma McMillan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)
6. DATE OF BIRTH: Sept (Month) 22, (Day) 1902 (Year)
7. AGE: 18 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): At home
9. BIRTHPLACE (State or Country): Okla
10. NAME OF FATHER: Fred Stevenson
11. BIRTHPLACE OF FATHER (State or Country): Kans
12. MAIDEN NAME OF MOTHER: Lillie Cloud
13. BIRTHPLACE OF MOTHER (State or Country): N. J.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jay McMillan
(Address) Kootenai, Ida.
15.
Filed ..... 19 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11, (Day) 1920. (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept. 8 1920, to Sept 11 1920, that I last saw her alive on Sept 11 1920, and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Puerperal Septicemia
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Childbirth
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Floyd [illegible] M. D.
Sept 11 1920. (Address) Sandpoint, Ida.
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.
18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence
19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Sept 13 1920.
20. UNDERTAKER: B. H. Cruzen ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2156
File No. 31687
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint
(No. City Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (Infant) Le Huquet.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single.

6. DATE OF BIRTH: Sept. 19, - 20. 1 (Month) (Day) (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many.... hrs. or 30 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Jno. A. Le Huquet.

11. BIRTHPLACE OF FATHER (State or Country): Alabama.

12. MAIDEN NAME OF MOTHER: Joy Newland.

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. Wendel.
(Address) Sandoint, Ida.

15. Filed Oct 9 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 19, -20 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 1920 to Sept-19- 1920, that I last saw him alive on Sept-19- 1920, and that death occurred on the date stated above, at 11 30 M.

The CAUSE OF DEATH* was as follows:
Premature birth
(4 mo Gestation)

....(Duration) ....Yrs....mos....ds.

Contributory (Secondary)
....(Duration) ....yrs....mos....ds.

(Signed) Floyd G Wendle M. D.
Sept 20 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Sept, 20, 1920.

20. UNDERTAKER: B. W. PUGH. ADDRESS: SANDPOINT. IDA.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31088

1. PLACE OF DEATH
County of Bonner
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. Sandpoint, Ida St.)

2. FULL NAME Emma F. Keough

Registered No.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widowed

6. DATE OF BIRTH: April 4 (Month) (Day) 1875 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): at Home

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: — Cook

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Emma Cook

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edward Keough
(Address) Sandpoint, Ida.

15. Filed Sept 14 1920 F. E. Bridier
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 13, (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1920 to Sept 13 1920
that I last saw her alive on Sept 12 1920
and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma Ventriculi

(Duration) One Yrs. No mos. No ds.
Contributory (Secondary) Asthenia
— (Duration) — yrs. — mos. 10 ds.

(Signed) F. E. Bridier M. D.
Sept 14 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Sept 14 1920.
20. UNDERTAKER: [redacted] Lynch ADDRESS: Sandpoint, Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31689

Registered No. .....

1. PLACE OF DEATH.

County of Bonner

City of Laclede

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Maxine Edwards

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. March 13 (Month) (Day) 1914 (Year)

7. AGE: 6 Yrs. 5 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer): none

9. BIRTHPLACE (State or Country): Laclede Ida.

10. NAME OF FATHER: Marion M Edwards

11. BIRTHPLACE OF FATHER (State or Country): Kansas ~~Woodbury~~

12. MAIDEN NAME OF MOTHER: Jennie Halverson

13. BIRTHPLACE OF MOTHER (State or Country): Minn. Laclede Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): Marion M Edwards

(Address): Laclede Idaho

15. Filed Sept 20 1920 H.O. Didier, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 14, (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1920, to Sept 14 1920, that I last saw her alive on Sept 14 1920, and that death occured on the date stated above, at 11 AM.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) Yrs. mos. 6 ds.

Contributory (Secondary) .....

(Duration yrs. mos. ds.

(Signed) H.O. Didier M. D.

9/24 1920 (Address) Laclede

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Laclede Ida. DATE OF BURIAL: 191

20. UNDERTAKER: H.E. Pugh ADDRESS: Sandpoint

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31690

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 23

1. PLACE OF DEATH

County of Bonner

City of Priest River, Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 85

Primary Registration District No. 2186

(No. ..... , ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dorthy Evylin Nelson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan. ~~June~~ (Month) 4th (Day) 1919 (Year)

7. AGE: 1 Yrs. 8 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Ole Nelson

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Odelia Strand

13. BIRTHPLACE OF MOTHER (State or Country): S. Dak.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ole Nelson

(Address) Newport Wash

15. Filed Oct 1 1920 C. P. Gettys Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 5 1920, to Sept 9 1920, that I last saw her alive on Sept 9 1920, and that death occurred on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Enter-Colitis

(Duration) — Yrs. — mos. 7 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) C. P. Gettys M. D.

Oct. 1 1920. (Address) Priest River, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Newport, Wn. DATE OF BURIAL: Sept. 11 1920.

20. UNDERTAKER: Wm. Davis. ADDRESS: Newport, Wn.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 215-0
File No. 31691
Registered No. 135

1. PLACE OF DEATH
County of Bannock
City of Idaho Falls
(No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leslie Ernest Webb
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 2 1900 (Month) (Day) (Year)

7. AGE: 20 Yrs. 6 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Francis A. Webb

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Martha Darling

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Francis A Webb
(Address) Pocatello Idaho

15. Filed Oct 4 1920
Guy Simmons
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. October 29 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1920, to Sept 29 1920, that I last saw him alive on Sept 29 1920, and that death occurred on the date stated above, at 3:15 P.M.
The CAUSE OF DEATH* was as follows:

Heart Appendicitis

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. H. Clews M. D.
Oct 9 1920 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 3 days. In the State Same yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Pocatello Idaho

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery | DATE OF BURIAL: Oct 1 1920

20. UNDERTAKER: Taylor-Edwards | ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31692

Registration District No. 73

Primary Registration District No. 2170

(No. ..... St.)

Registered No. 134

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bannock

City of Ida Falls

2. FULL NAME Velma Blatter

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. November 4 1919
(Month) (Day) (Year)

7. AGE: 0 Yrs. 10 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Eudora Blatter

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Margaret Hiatt

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E Blatter
(Address) RD 3 City

15. Filed Sept 7 1920 [illegible] Local Registrar
Dated

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1920, to Sept 12 1920, that I last saw h.. alive on Sept 7 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Likely "Pneumonia" I saw the baby only once at my office sept 7, 1920
(Duration) ..... Yrs. ..... mos. One ds.
Contributory (Secondary) Summer Diarrhoea
(Duration ..... Yrs. ..... mos. 10 ds.

(Signed) H R Hatch M. D.
9/17 1920 (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ammon, Ida — DATE OF BURIAL: Sept 17 1920

20. UNDERTAKER: [illegible] — ADDRESS: Ida Falls

SYMS - YORK CO. PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31693

Registered No. 133

1. PLACE OF DEATH.

County of Bannock

City of Ida Gate

(No. ..... St.)

Registration District No. 73

Primary Registration District No. 2 1 1 0

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wm Adolph Tofte

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feby (Month) 30 (Day) 1901 (Year)

7. AGE: 19 Yrs. 6 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Geo. A. Tofte

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ely. E. McKnight

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo A Tofte

(Address) Idaho Falls

15. Filed Sept 14 - 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1920 to Sept 9 1920, that I last saw him alive on 1920, and that death occured on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

Fracture of Base of Skull by fall down Elevator shaft of L D S Hospital near ground floor

(Duration) Yrs. mos. 2 minutes ds.

Contributory (Secondary)

(Duration yrs. mos. ds.

(Signed) H R Hatch M. D.

Sept 9 1920 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 9/11/1920

20. UNDERTAKER: E. Ellinwood — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PRTS. & BOKS. 24658

Dr Hatch

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31694

Registered No. 132

1. PLACE OF DEATH.

Registration District No. 73

Primary Registration District No. 21-0

County of Bonneville

City of Idaho Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Vogle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH. Aug (Month) 31 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many 1½ hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Geo Vogle

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mabel Dawson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Vogle

(Address) Idaho Falls

15. Filed Sept 1 1920 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31 1920, to Aug 31 1920, that I last saw him alive on Aug 31 1920, and that death occured on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Asphyxia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Congenital atelectasis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jabez W. Hirst M. D.

9/3 1921 (Address) Idaho Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 9-1 1920

20. UNDERTAKER: C. C. Sherwood — ADDRESS: Idaho Falls

Dr Neal

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO. PTRS. & STGS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 13
Primary Registration District No. 2170
File No. 31695
Registered No. 737

1. PLACE OF DEATH
County of Bannock
City of Ida Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mariano Figueroa

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Mexican	?

6. DATE OF BIRTH ?
(Month) (Day) 1 (Year)

7. AGE about 40 yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Work in Beet field
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mexico

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Dunwoody
(Address) Ida Falls Ida

15. Filed July 19 20 — A. Furniss, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July 20 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17 1920 to July 20 1920
that I last saw h. alive on July 20 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Peritonitis
Following operation for
Appendicitis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) J. R. Shupe M. D.
7/21 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	7-21 1920

20. UNDERTAKER	ADDRESS
C. C. Dunwoody	Ida Falls

J. R. Shupe

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31696

Registered No. 130

1. PLACE OF DEATH.

County of Bingham

City of Bonneville Milo

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2130

(No. ..... St.)

2. FULL NAME Bert Virgil Olsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH. June (Month) 8 (Day) 1919 (Year)

7. AGE: 1 Yrs. 2 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Milo Idaho

10. NAME OF FATHER: R. J. Olsen

11. BIRTHPLACE OF FATHER (State or Country): Mass

12. MAIDEN NAME OF MOTHER: Caroline Davis

13. BIRTHPLACE OF MOTHER (State or Country): Milo - Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R. J. Olsen

(Address) Rigby R.D. # 2 Milo

15. Filed Sept 15 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Linwoodey M.D.

9/15 1920 (Address) Idaho Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Milo — DATE OF BURIAL: 9/14 1920

20. UNDERTAKER: C E Linwoodey — ADDRESS: Ida Falls

Dr. Fisher Reader

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 V 0
File No. 31698
Registered No. 124

1. PLACE OF DEATH
County of Bonneville
City of Ida Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Oswald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: June (Month) 22 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. S. Oswald

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Zoe Mill

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A S Oswald
(Address) Idaho Falls

15. Filed Sept. 1V 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 7-14-1920 to 7-18-1920
that I last saw her alive on 7-18-1920
and that death occurred on the date stated above, at 7P M.
The CAUSE OF DEATH* was as follows:

Intestinal Intoxication

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J C Hallisin M. D.
7-20 1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Collinan Ida. — DATE OF BURIAL: 7/20 1920

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

J C Hallisin

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31699
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 79
Primary Registration District No. 2156

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

2. FULL NAME Frank Henry Green

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 10 (Day) 1869 (Year)

7. AGE: 51 Yrs. 6 Mos. 22 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. F. H. Green
(Address) Bonners Ferry Ida.

15. Filed Sept. 3rd, 1920. E E Fry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1919 to Sept. 3rd, 1920.
that I last saw him alive on Sept. 3rd. 1920.
and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Cirrhosis of the liver
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
9/3 1920. (Address) Bonners Ferre, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Idaho — DATE OF BURIAL: Sept 5 1920

20. UNDERTAKER: Stookey — ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FC

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 31700
Registered No. 124

1. PLACE OF DEATH

County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca J McNair

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July 5 1835 (Month) (Day) (Year)

7. AGE: 85 Yrs. 2 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Elijah Hussey

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Elizabeth McGee

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D R McNair
(Address) Caldwell, Ida.

15. Filed Sept. 28 1920 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1920, to Sept 26 1920, that I last saw her alive on Sept 26th 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Valvular heart trouble

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Old age
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Hamer M. D.
9/29 1920 (Address) Middleton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 9-28 1920

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ..... St.)

File No. 31701
Registered No. 193

1. PLACE OF DEATH

County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Victoria Geal

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
female	white	Married

6. DATE OF BIRTH: May (Month) 12 (Day) 1853 (Year)

7. AGE: 70 Yrs. 4 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home nurse.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: Philip A. Geal

11. BIRTHPLACE OF FATHER (State or Country): Missouri.

12. MAIDEN NAME OF MOTHER: Don't know.

13. BIRTHPLACE OF MOTHER (State or Country): Missouri.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Prudence Parker
(Address) Caldwell, Ida.

15. Filed 9-30-1920 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 192 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1920 to Sept 27 1920 that I last saw her alive on Sept 27 1920 and that death occurred on the date stated above, at 9-27 M.

The CAUSE OF DEATH* was as follows:
Acute ileo-colitis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. O. Montgomery M. D.
Sept 29 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 9-30 1920

20. UNDERTAKER: C. V. Eckhart ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1003
File No. 31702
Registered No. 122

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ada Perkins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	

6. DATE OF BIRTH Sept 8 1916 (Month) (Day) (Year)

7. AGE 4 Yrs. Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER T. J. Perkins

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Beatrice Best

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Callie Lee
(Address) Caldwell, Ida

15. Filed Sept 26 1920 John S. Smeyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1920 to Sept 27 1920 that I last saw her alive on Sept 27 1920 and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:
Diphtheria
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. M. Foley M. D.
9-28 1920 (Address) Caldwell Ida

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	9-28 1920
20. UNDERTAKER E. V. Peckham	ADDRESS Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 31703
Registered No. 120

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Miranda Louisia Stevenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Oct (Month) 13 (Day) 1845 (Year)

7. AGE
74 Yrs. 11 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Tennessee

10. NAME OF FATHER John Yorkum

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Miranda Dugan

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John S. Stevenson
(Address) Parma Rt 2 Ida

15.
Filed Sept. 24 1920 John V. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 23 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 13 1918, to Sept. 23 1920
that I last saw her alive on Sept 8 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Anemia (Pernicious)

..... (Duration) Yrs. 8 mos. ..... ds.
Contributory (Secondary) Gastritis Chronic
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Haley M. D.
9-23 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 9-24 1920

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 31704
Registered No. 119

1. PLACE OF DEATH
County of Canyon
City of Wilder
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donald Robert Bush

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: March 12 (Month) (Day) 1920 (Year)

7. AGE: ... Yrs. 5 Mos. 10 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Fred Bush

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Julia Sample

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Bush
(Address) Wilder Ida

15. Filed Sept. 24 1920 — John L. Meyer, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 22 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1920, to Sept 21 1920, that I last saw h... alive on Sept 20 1920, and that death occurred on the date stated above, at 9-15 A.M.

The CAUSE OF DEATH* was as follows:

1 Hydrophobia

.....(Duration) ... Yrs. ... mos. 3 ds.

Contributory (Secondary)

.....(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.

Sept. 1920. (Address) Wilder Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	9-24 1920
20. UNDERTAKER	ADDRESS
C. V. Peckham	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ..... St.)

File No. 31705
Registered No. 118

1. PLACE OF DEATH
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louellen McCullough
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 28 (Day) 1919 (Year)

7. AGE: ... Yrs. 9 Mos. 19 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Caldwell, Ida

10. NAME OF FATHER: Iris. McCullough

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Blanch Martin

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Blanche McCullough
(Address)

15. Filed Sept. 18 1920 John V. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1920 to Sept 17 1920
that I last saw her alive on Sept 17 1920
and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(Duration) ... Yrs. ... mos. 3 ds.
Contributory (Secondary) Acute Enteritis
(Duration) ... yrs. ... mos. 12 ds.

(Signed) W. M. Caley M. D.
9-18 1920 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Sept 19 1920

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
(No. Canyon Co. Case St.)
File No. 31706
Registered No. 117

1. PLACE OF DEATH
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Milton Shreve
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Widower

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
80 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Illinois

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. V. Peckham
(Address) Caldwell Ida

15.
Filed Sept. 17 - 1920 John H. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1, 1920 to Sept 17 1920
that I last saw h[illegible] alive on Sept 16 1920
and that death occurred on the date stated above, at 10 A M.
The CAUSE OF DEATH* was as follows:
Cystitis — Uremia —

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. V. Peckham M. D.
9/18 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	9-17 1920
20. UNDERTAKER	**ADDRESS**
C. V. Peckham	Caldwell, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

al Falkum

County Case

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31707

Registered No. 13

1. PLACE OF DEATH.

County of Canyon

City of Parma

Registration District No. .....

Primary Registration District No. 2007

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George F. Camp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH. July (Month) 17 (Day) 1870 (Year)

7. AGE: ..... Yrs. 50 Mos. 1 ds. 15

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER Eugene F Camp

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Helen L Stewart

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Francis M Camp

(Address) Parma Ida

15. Filed Sept. 1920 Lulu Baldwin Local Registrar.

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 13 1920, to Sept 2 1920, that I last saw him alive on Sept. 1 1920, and that death occured on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:

Cardio-circulatory renal disease entity of probably many years

(Duration) about 7 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Uremic Convulsions

(Duration ..... yrs. ..... mos. 3½ ds.

(Signed) Chas. B. Allen M. D.

3/9 1920 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fargo — DATE OF BURIAL: Sept 4 1920

20. UNDERTAKER: Peckham Fun Co — ADDRESS: Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31708

Registered No. 15

1. PLACE OF DEATH.

County of Canyon Co

City of Franklin

Registration District No. 8

Primary Registration District No. 2007

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Manisali

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	

6. DATE OF BIRTH. 9 (Month) 5 (Day) 20 (Year)

7. AGE .....Yrs. 3 Mos. .....ds.

IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER Mark Manisali

11. BIRTHPLACE OF FATHER (State or Country) Calf

12. MAIDEN NAME OF MOTHER Rozella Hamilton

13. BIRTHPLACE OF MOTHER (State or Country) Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) E E Hamilton

(Address) Parma R-2

15.

Filed Sep 8 1920 Lulu Waldrop Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1920, to Sept. 8 1920, that I last saw her alive on Sept. 8 1920, and that death occured on the date stated above, at noon M.

The CAUSE OF DEATH* was as follows:

Uremia poisoning - contaminated corn whisky.

(Duration) 0 Yrs. 0 mos. 2 ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm S. Chambers M. D.

Sept 8 1920 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Franklin cemetary	Sept 9 1920
20. UNDERTAKER	**ADDRESS**
Peckham Fun Co	Parma

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYRNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2007
File No. 31710
Registered No. 17

1. PLACE OF DEATH
County of Canyon
City of Parma
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lillie S. Terry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Widowed)

6. DATE OF BIRTH: Feb 11 (Month) (Day) 1878 (Year)

7. AGE: 42 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: McHenry Long

11. BIRTHPLACE OF FATHER (State or Country): Don't know

12. MAIDEN NAME OF MOTHER: Mrs Meats

13. BIRTHPLACE OF MOTHER (State or Country): Don't know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. E. Terry
(Address) Mt Sterling Ills

15.
Filed Sep 23 1920
Luther Waldrop
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 9 1920 to Sept 23 1920 that I last saw h[illegible] alive on Sept 13 1920 and that death occurred on the date stated above, at 4:15 a.m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. M. Hutchell M. D.

9/23 1920 (Address) Parma

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Sterling Ill — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: L. V. Beckham — ADDRESS: Caldwell Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 31711
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Reed
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: July (Month) 11 (Day) 1911 (Year)

7. AGE: 9 Yrs. 2 Mos. ..... ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In School
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C C Reed

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Ruth Clapp

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): C C Reed
(Address): Nampa Ida

15. Filed Oct 2 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-20 1920, to 9-20 1920, that I last saw her ~~alive~~ dead on 9-20 1920, and that death occurred on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:
Accidental - run down by an Automobile

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H E Robinson M. D.
9-23 1920 (Address) Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida | DATE OF BURIAL: 9-20 1920

20. UNDERTAKER: Fred K Robinson | ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31712

Registration District No. 7
Primary Registration District No. 1004
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Lawrence McCarthy
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 31 (Day) 1901 (Year)

7. AGE: 18 Yrs. 11 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business or establishment in which employed (or employer): Employed

9. BIRTHPLACE (State or Country): Chicago, Ill

10. NAME OF FATHER: Lawrence McCarthy

11. BIRTHPLACE OF FATHER (State or Country): Chicago, Ill

12. MAIDEN NAME OF MOTHER: Catharine Lavery

13. BIRTHPLACE OF MOTHER (State or Country): Chicago, Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred R Robinson
(Address) Nampa

15. Filed Sept 20 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Crushed skull - caused by shifting of structural steel on flat car H.V. 53799
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. V. Beckham Coroner M.D.
9-9 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill — DATE OF BURIAL: 9-16-1920

20. UNDERTAKER: F R Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V.S. No. 5-25 ... 1-30 ...

1. PLACE OF DEATH

State Idaho
BOARD O. HEALTH
Bureau of Vital Statistics

County of Canyon
Registration District No.
Primary Registration District No.
File No.

City of Nampa
(No. ..., ... St.)
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence John McCarthy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 10 (Month) 31 (Day) 1901 (Year)

7. AGE: 18 Yrs. 11 Mos. ... ds. 21

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business or establishment in which employed (or employer): Employed

9. BIRTHPLACE (State or Country): Chicago Ill.

10. NAME OF FATHER: Lawrence McCarthy

11. BIRTHPLACE OF FATHER (State or Country): Chicago Ill.

12. MAIDEN NAME OF MOTHER: Catherine Lavery

13. BIRTHPLACE OF MOTHER (State or Country): Chicago Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Catherine Hart.
(Address): 3223 - Normal Ave

15.
Filed ... 19...
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
... 19...
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to ... 19...
that I last saw h... alive on ... 19...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

...
...
...
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
... 19... (Address) ...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill. | DATE OF BURIAL: 9-16 1920

20. UNDERTAKER: F. K. Robinson | ADDRESS: Nampa Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 31713
Registered No.

1. PLACE OF DEATH
County of Canyon
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Mai
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Feb (Month) 2 (Day) 1882 (Year)

7. AGE: 38 Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Geo Hartman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Richard Mai
(Address) Nampa Ida
Caldwell #1

15. Filed Sept. 30 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 24 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2/26 19 20, to 9/24 19 20
that I last saw h.. alive on Sep 21 19 20
and that death occurred on the date stated above, at about 3 A.M.

The CAUSE OF DEATH* was as follows:
Cardiac rupture of
compensation
(Duration) 3 Yrs. — mos. — ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A. B. Johnson M. D.
9/24 19 20 (Address) Nampa Ida
Box

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dearborn Iowa — DATE OF BURIAL 19

20. UNDERTAKER: Fred K Robinson — ADDRESS Nampa Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31715

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mabel M Weeks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 19 (Day) 1892 (Year)

7. AGE: 28 Yrs. 7 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Peter Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweeden

12. MAIDEN NAME OF MOTHER: Josephine Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. L. Weeks

(Address) Nampa Ida

15. Filed Sept. 30 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 17 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Sept~~ May 31, 1920 to Sept 17 1920 that I last saw her alive on Sept 16 1920 and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... Yrs. ..... mos. 22 ds.

Contributory (Secondary) Exhaustion from nursing and

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. R. Proctor M. D.

Sept 17 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? at Idaho Falls

Former or usual residence Idaho Falls

19. PLACE OF BURIAL OR REMOVAL: Thornton Ida — DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: F F Peterson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 31716
Registered No.

1. PLACE OF DEATH
County of
City of
(No. , St.)
If death occure away from usual residence, give facts called for under special information.

2. FULL NAME John Emery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 29 (Day) 1873 (Year)

7. AGE: 46 Yrs. 9 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Robert Emery

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Mary Ann Condor

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clara Adelle Emery
(Address) Melba Ida

15. Filed Oct 7 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1920, to Sept. 28 1920, that I last saw him alive on Sept 28 1920, and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation and edema of the lungs

(Duration) — Yrs. — mos. 3 ds.

Contributory (Secondary) Diabetes

(Duration) 4 yrs. mos. ds.

(Signed) Samuel A. Swayne M. D.

9-30 1920 (Address) Melba, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chester Ida | DATE OF BURIAL: Oct - 1920

20. UNDERTAKER: F. R. Robinson | ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM 2

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 3171

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. Mercy Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph C Robinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Apr (Month) 27 (Day) 1863 (Year)

7. AGE: 57 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Molder
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Ezra Robinson

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Chinten

13. BIRTHPLACE OF MOTHER (State or Country): N. Scotia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lena J Robinson
(Address) Meridian Oregon

15.
Filed Oct 7 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1920 to Oct 3 1920
that I last saw him alive on Oct 3 1920
and that death occurred on the date stated above, at 11:30 A.M.
The CAUSE OF DEATH* was as follows:
Valvular trouble
Dilated heart
(Duration) 2 Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.
(Signed) H S Murray M. D.
10/5/1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sheridan Oregon
DATE OF BURIAL ... 19...
20. UNDERTAKER
ADDRESS

Murray

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 31718
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. Mercy Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Victoria Viola Purse
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Apr (Month) 24 (Day) 1862 (Year)

7. AGE: 58 Yrs. — Mos. — ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: P Shaw

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J N Purse
(Address) Nampa Ida

15. Filed Oct. 7 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 27 1920, to Sept 19 1920, that I last saw her alive on Sept 19 1920 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Acute dilitation of heart
(Prostration)
(Duration) X Yrs. X mos. 4 ds.
Contributory (Secondary) Carcinoma Uterus metastatic
(Duration) 2 yrs. X mos. X ds.

(Signed) Leo W Chilton M. D.
9/23 1920 (Address) For Dr Wm Techmar Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: A. L. Cem — DATE OF BURIAL: 9-21 1920

20. UNDERTAKER: J K Robinson — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31719
Registered No.

1. PLACE OF DEATH
County of Canyon. Registration District No. 7
City of Nampa Ida (No. 128. 13th ave. St.) Primary Registration District No. 1006
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl D Nicholaysen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH June 28 1919 (Month) (Day) (Year)

7. AGE 1 Yrs. 2 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER Nick Nicholaysen

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Ella Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Nick Nicholaysen
(Address) Nampa Ida

15. Filed Oct. 7 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep 8 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 4 1920, to Sep 8 1920 that I last saw her alive on Sep 8, 2 P.M. 1920 and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Acute Gastro-Enteritis

(Duration) Yrs. mos. 12 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Leo W Chilton M. D.
19 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Nampa Ida — DATE OF BURIAL 8-10 1920

20. UNDERTAKER Fred K. Robinson — ADDRESS Nampa Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 31720
Registered No.

1. PLACE OF DEATH
County of Cassia
City of Arbon
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas W. McClain

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 5 (Day) 70 (Year)

7. AGE: 50 Yrs. 7 Mos. 27 Ds. — If LESS than 1 day, how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Walter McClain

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Mary Gosnell

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Robert McClain
(Address):

15. Filed Sept 16 1920. John Geraghty, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound
Suicidal

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. B. Galloway Coroner M. D.
Sept 19 1920. (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. P. Grossman — ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Patterson

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

31721

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 422
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. R. F. D. # 3 St.)

2. FULL NAME Milton Levi Hansen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 20. (Day) 1894 (Year)

7. AGE: 26 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Hans Peter Hansen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Anna A. Frandsen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. L. Hansen
(Address) R. F. D. # 3. Burley Ida.

15. Filed Sept. 13th 1920. W. J. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2 1920 to Sept. 12 1920
that I last saw him alive on Sept. 12 1920.
and that death occurred on the date stated above, at 1:30 A. M.

The CAUSE OF DEATH* was as follows:
Pneumonia Hypostatic

.....(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
9-13 1920. (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pella Ida. DATE OF BURIAL: Sept 13 1920

20. UNDERTAKER: L. B. Talloogy. ADDRESS: Burley Ida.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

31722

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 453

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2196
(No. ....., ... St.)

2. FULL NAME Anton Wiedemann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) 1870 (Year)

7. AGE: 50 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Bohemia

10. NAME OF FATHER: Unknown.

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Addue
(Address) Heaven Ida.

15. Filed Sept 28 1920 W. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at ....., ...M.
The CAUSE OF DEATH* was as follows:
Broken Neck,
Cause unknown,
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) L. B. Galloway Coroner M. D.
9/24/20. (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Sept. 26 1920.
20. UNDERTAKER: L. B. Galloway ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

31723 Cooper

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 5.....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2196
(No. ....., ... St.)

2. FULL NAME Maud L. Bemis

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (or the word.)

6. DATE OF BIRTH: May (Month) 17 (Day) 1890 (Year)

7. AGE: 30 Yrs. 4 Mos. 9 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Joseph F Bemis

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Albena Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph F. Bemis
(Address) Burley Ida.

15. Filed Oct 1 1920
D. J. E. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 — 1920 to Sept 26 — 1920 that I last saw her alive on Sept 26 — 1920 and that death occurred on the date stated above, at 5 pm M.

The CAUSE OF DEATH* was as follows:

Phlegmasia following an operation

— (Duration) — Yrs. — mos. 4 ds.

Contributory (Secondary) Suppuration Ovaritis

— (Duration) — Yrs. — mos. — ds.

(Signed) G. H. Cook M. D.

9/1 — 1920 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Sept 27. 1920.

20. UNDERTAKER: L. B. Scoggin ADDRESS: Burley Ida

FORM V. S. No. 5-12 M. 6-15-17.

Cooper.

31724

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 434

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117

Primary Registration District No. 2196

(No. ....., ... St.)

2. FULL NAME Ellen Tilley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Single

6. DATE OF BIRTH. Aug. (Month) 23 (Day) 1 (Year)

7. AGE # Yrs. 1 Mos. 3 ds.

IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER James Tilley

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Rachel Thomas.

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Tilley

(Address) Burley Ida. R.F.D.

15. Filed Oct. 4, 1917 Dr. J. E. Patterson, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 26 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 24 - 1920. to Sept 26 - 1920. that I last saw h[er] alive on Sept 26 - 1920. and that death occurred on the date stated above, at 1:00 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) — Yrs. — mos. 10 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) G. H. Cooper M. D.

10/1 1920 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Burley Ida. **DATE OF BURIAL** Sept 28 1920.

20. UNDERTAKER L. B. Gallogly **ADDRESS** Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31725
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Albion
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME David Lewis, Sr.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Widowed

6. DATE OF BIRTH: May (Month) 15 (Day) 1818 (Year)

7. AGE: 102 Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Sawyer
(Address) Albion Ida.

15.
Filed ..... 191....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191...
and that death occurred on the date stated above, at .....

The CAUSE OF DEATH* was as follows:
Senility
.....
.....
.....(Duration) ..... Yrs..... mos..... ds.
Contributory .....
(Secondary)
.....(Duration) ..... Yrs..... mos..... ds.

(Signed) L.B. Talloghy Coroner M. D.
Sept 9. 1920. (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Albion Ida.
DATE OF BURIAL: Sept. 10 1920

20. UNDERTAKER: L.B. Talloghy
ADDRESS: Burley Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 58 2

Primary Registration District No. 2138

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31726

Registered No.

1. **PLACE OF DEATH**

County of Camas

City of Conal

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Jennie Peck

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: F.

4. **COLOR OR RACE**: white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): widowed

6. **DATE OF BIRTH**: May (Month) 17 (Day) 1857 (Year)

7. **AGE**: 68 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Iowa

10. **NAME OF FATHER**: — —

11. **BIRTHPLACE OF FATHER** (State or Country): — —

12. **MAIDEN NAME OF MOTHER**: — —

13. **BIRTHPLACE OF MOTHER** (State or Country): — —

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs Thompson

(Address) Conal, Idaho

15. Filed Oct 11 1920 L Wilencheck Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Sept (Month) 4 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Aug 30 1920, to Sept 3 1920

that I last saw h.. alive on Sept 3 1920

and that death occurred on the date stated above, at 7 a M.

The **CAUSE OF DEATH*** was as follows:

Cerebral Hemorrhage.

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Wilencheck M. D.

Oct 11 1920. (Address) Fairfield Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** | **DATE OF BURIAL** ..... 19.....

20. **UNDERTAKER** | **ADDRESS**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31727

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No.
Registered No. 44

1. PLACE OF DEATH
County of Oneida
City of Gibert
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lucy Ann Dickason
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 5 (Day) 1843 (Year)

7. AGE: 76 Yrs. 10 Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Benj. Reed

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. B. Dickason
(Address) Gilbert Idaho

15. Filed Sept 30 1920 J. M. Tinsley Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1915 to Sept 14 1920 that I last saw h[er] alive on August 1920, and that death occurred on the date stated above, at 8 00 M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. M. Tinsley M. D.

9/15 1920 (Address) Hopkins Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gilbert Ida — DATE OF BURIAL: Sept 15 1920

20. UNDERTAKER: F. B. Dickason — ADDRESS: Gilbert Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31729
Registered No. .....

1. PLACE OF DEATH.

County of .....

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Ventress Bee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH. August (Month) 3 (Day) 1917 (Year)

7. AGE 3 Yrs. 7 Mos. 17 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... X X
(b) General nature of industry, business, or establishment in which employed (or employer)... X X

9. BIRTHPLACE (State or Country) Hamilton Montana

10. NAME OF FATHER Chas Ray Bee

11. BIRTHPLACE OF FATHER (State or Country) Salem Oregon

12. MAIDEN NAME OF MOTHER May Miller

13. BIRTHPLACE OF MOTHER (State or Country) Bloomfield Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Ray Bee
(Address) Drummond Idaho

15. Filed 10/1 1920 C. A. Meadows, Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-19 1920, to 9-30- 1920, that I last saw h-- alive on 9-29- 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Gastro - Enteritis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) ....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Meadows M. D.

9/30 1920 (Address) Ashton, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ashton Idaho — DATE OF BURIAL .....191....

20. UNDERTAKER Lewis Lister — ADDRESS Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of .....

City of .....

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

File No. 22730

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wanda C. Marshall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. August 28 1920
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Ashton Idaho

10. NAME OF FATHER Frank Marshall

11. BIRTHPLACE OF FATHER (State or Country) Panguitch Utah

12. MAIDEN NAME OF MOTHER Vivian Crouch

13. BIRTHPLACE OF MOTHER (State or Country) Glendale Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Frank Marshall
(Address) Ashton Idaho

15.
Filed 9/24 1920
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 23 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 20 1920, to Sept 23 1920, that I last saw her alive on Sept 23 1920, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. Hays, M. D.

Sept 23 1920 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~ Ashton Idaho — DATE OF BURIAL 9-24 1920

20. UNDERTAKER Lewis Riser — ADDRESS Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 21731
Registered No. 47

1. PLACE OF DEATH
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 2118
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lydia Romney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	white	Single

6. DATE OF BIRTH: May (Month) 7 (Day) 1911 (Year)

7. AGE: 9 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: J. C. Romney.

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lydia Ann Naylor

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. C. Romney
(Address) Preston, I.

15. Filed Sept. 18 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1920 to Sept 16 1920
that I last saw h.er alive on Sept 16 1920
and that death occurred on the date stated above, at 9:12 M.
The CAUSE OF DEATH* was as follows:
Bronchis Pneumonia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Ether anesthesia
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. M. Cutler Jr. M. D.
19..... (Address) Preston Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Canada

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Preston	9/18/1920

20. UNDERTAKER	ADDRESS
G. C. Lundquist	Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31732

Registered No. .....

1. PLACE OF DEATH.

County of .....

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. .....

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marget Bell Zimmerman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. March (Month) 13 (Day) 1919 (Year)

7. AGE: 1 Yrs. 6 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ashton Idaho

10. NAME OF FATHER Bert R Zimmerman

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Florence Whittemore

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Bert R Zimmerman

(Address) Driggs Idaho

15. Filed 9/17 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1920, to Sept 16 1920, that I last saw h[illegible] alive on Sept 16 1920, and that death occured on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) E. V. Evans M. D.

Sept 17 19 20 (Address) Ashton Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho — DATE OF BURIAL: 9-17 1920

20. UNDERTAKER: Lewis-Kiser — ADDRESS: Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24854

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 31734
Registered No. 60

1. PLACE OF DEATH
County of Franklin
City of Franklin (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Haworth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: October (Month) 7 (Day) 1912 (Year)

7. AGE: 7 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Franklin Idaho

10. NAME OF FATHER: Thomas Haworth

11. BIRTHPLACE OF FATHER (State or Country): Franklin Idaho

12. MAIDEN NAME OF MOTHER: Blanda Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Salt Lake City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Thos. Haworth
(Address) Franklin Idaho

15. Filed Oct. 8 1920 — B. A. Cutler, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 15 1920, to Sept. 14 1920, that I last saw her alive on Sept. 13 - 1920, and that death occurred on the date stated above, at 4A M.
The CAUSE OF DEATH* was as follows:
Tubercular Meningitis
(Duration) - Yrs. 3 mos. - ds.
Contributory (Secondary) Acute Tonsilitis
(Duration) - yrs. - mos. 5 ds.
(Signed) G. W. States M. D.
Sept 15 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Franklin Idaho — DATE OF BURIAL: Sept. 16 1920

20. UNDERTAKER: P. J. Lowe — ADDRESS: Franklin Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 31735
Registered No. 45

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hilda Stocks
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write one word.)

6. DATE OF BIRTH: February (Month) 6 (Day) 1910 (Year)

7. AGE: 10 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School child.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lewiston Utah

10. NAME OF FATHER: Henry Stocks

11. BIRTHPLACE OF FATHER (State or Country): Lewiston Utah

12. MAIDEN NAME OF MOTHER: Minnie C Dopp

13. BIRTHPLACE OF MOTHER (State or Country): Lewiston Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Henry Stocks
(Address) Preston Idaho

15.
Filed ..... 19.....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1 1920, to Sept 17 1920, that I last saw h-er alive on Sept. 17 1920 and that death occurred on the date stated above, at 9 10 P. M.
The CAUSE OF DEATH* was as follows:

Diabetis Mielitis

(Duration) ✓ Yrs. 6 mos. ✓ ds.
Contributory (Secondary) Indescretion in diet.
(Duration) ✓ yrs. — mos. ✓ ds.

(Signed) G. W. Stayes M. D.
Sept. 18 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Utah	9/19 1920
20. UNDERTAKER: J. T. Lundquist	ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31736
Registered No. 466

1. PLACE OF DEATH
County of Franklin
City of Clifton
(No. ..... St.)
If death occure away from usual residence, give facts called for under special information.

Registration District No. 27
Primary Registration District No. 219

2. FULL NAME Beatrice Marler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: April (Month) 5 (Day) 1920 (Year)

7. AGE: Yrs. 5 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Frank J. Marler

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Jane N. Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lacey Perkins
(Address) Clifton Idaho

15. Filed Sept. 24 1920 D. A. Reed
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 23, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from No Doctor 19 ... to Afternoon 19 ..., that I last saw her alive on never saw her. 19 ..., and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Not known
Probably bowel trouble bowels were disturbed & moving freely
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) Albert P. Condie M. D.
19 ... (Address) Preston Idaho Register

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clifton Idaho.	Sept 25 1920
20. UNDERTAKER None	ADDRESS Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119.
File No. 31737
Registered No. 69

1. PLACE OF DEATH
County of Franklin
City of Fairview
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phillis Rawlins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: S (Write the word.)

6. DATE OF BIRTH: aug 9 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Henry H Rawlins

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Thresa Sorensen

13. BIRTHPLACE OF MOTHER (State or Country): New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry H Rawlings
(Address) Preston R 4 # 3

15. Filed Oct. 8 1920. D A Rutter Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: aug 16 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 9 1920, to Aug 16 1920, that I last saw h[illegible] alive on Aug 9 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Pneumonia — father called me by telephone said baby had pneumonia stole, he was away from home and in 20 min it was dead (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
8/17 1920. (Address) Curtis Ward

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview — DATE OF BURIAL: Aug 18 1920

20. UNDERTAKER: [illegible] Lundquist — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31738

Registered No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH

County of Gem

City of Emmett (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Craig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Nov. (Month) 2 (Day) 1919 (Year)

7. AGE: Yrs. 10 Mos. 23 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter D. Craig

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Maisie Rude

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Walter D. Craig

(Address) Emmett Idaho

15.

Filed Sept 28 1920

J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 18 1920 to Sept 25 1920 that I last saw h[illegible] alive on Sept 24 1920 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Enteritis colitis.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Burton O Clark M. D.

19 (Address) Emmett Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho

DATE OF BURIAL: 9/27 1920

20. UNDERTAKER: C. R. Buckmum

ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6
Primary Registration District No. 2411
File No. 31739

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. ....., ... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Davis Toothman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: June (Month) 30 (Day) 1830 (Year)

7. AGE: 90 Yrs. 2 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stationery Engineer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): West Va.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Toothman
(Address) Twin Falls, Ida.

15.
Filed Sept 28 1920 — J. D. Reynolds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 6 1920, to Sept 25 1920, that I last saw h[illegible] alive on Sept 10 1920, and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:
Nephritis
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration) .....yrs.....mos.....ds.
(Signed) Burton D Clark M. D.
.....19..... (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida
DATE OF BURIAL: 9/28 1920

20. UNDERTAKER: C. D. Buckenmeyer
ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31740

Registered No.

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6

Primary Registration District No.

(No. , St.)

2. FULL NAME Lydia Ann Gove

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widow

6. DATE OF BIRTH: July (Month) 31 (Day) 1864 (Year)

7. AGE: 56 Yrs. 2 Mos. 1 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J. B. Swayne

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Mary Sill

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Bruce Gove

(Address) Emmett Idaho

15. Filed 10-4 1920

J. K. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Sept 10~~ 1920, to Oct 1 1920, that I last saw h[illegible] alive on Oct 1 1920, and that death occurred on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Nephritis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Influenza two days ago

(Duration) Yrs. mos. ds.

(Signed) J. K. Reynolds M. D.

10/4 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho

DATE OF BURIAL: 10/5 1920

20. UNDERTAKER: O. D. Bucknum

ADDRESS: Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 10 10
(No. ....., ... St.)

File No. 31741
Registered No. .....

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Melvin B. Perkins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: May (Month) 10 (Day) 1911 (Year)

7. AGE: 9 Yrs. 3 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Burdette Perkins

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Effie Griffith

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) A B Griffith Ola Idaho

15. Filed 9/8/1920 J. K. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1920 to Sept 3 1920 that I last saw h.im alive on July 20 1920, and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Nefebritis
of Parenchymatous

(Duration) 1 Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis G Boyd M. D.
9/3 1920 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ola Idaho	9/4 1920

20. UNDERTAKER	ADDRESS
C D Bucknum	Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 1014
File No. 8242
Registered No. .....

1. PLACE OF DEATH
County of Gooding
City of Gooding
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Frances Berry
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: May (Month) 13 (Day) 1913 (Year)

7. AGE: 6 Yrs. 8 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Gooding Idaho

10. NAME OF FATHER: Clifford Earl Berry

11. BIRTHPLACE OF FATHER (State or Country): Pike Co. Ill.

12. MAIDEN NAME OF MOTHER: Verna A Tedman

13. BIRTHPLACE OF MOTHER (State or Country): Rochester, Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Berry
(Address) Gooding Ida

15. Filed 10-5- 1920 F. J. Carey M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb. (Month) 2. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1919 to Feb 2 1920, that I last saw her alive on Feb 2 1920 and that death occurred on the date stated above, at 11P M.

The CAUSE OF DEATH* was as follows: Chronic Brights Disease

(Duration) Yrs. 9 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J H Cromwell M. D.
2/2 1920 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gooding Cemetery	2/4 1920
20. UNDERTAKER	ADDRESS
A E Thompson	Gooding Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 1014
(No. ....., ... St.)

File No. 31743
Registered No. .....

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie L Hallbert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Oct (Month) 6 (Day) 1874 (Year)

7. AGE 56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Chas Pratt

11. BIRTHPLACE OF FATHER (State or Country): Do not Know

12. MAIDEN NAME OF MOTHER: Annie Pratt

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary March
(Address) Gooding Idaho

15. Filed 9-18 1920
F H Cary M D
Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) - 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-15 1920, to 9-18 1920, that I last saw her alive on 9-18 1920, and that death occured on the date stated above, at 11P M.

The CAUSE OF DEATH* was as follows:
Operation for gall bladder disease
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Intestinal adhesion
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) F H Cary M. D.
9-21 1920 (Address) Gooding Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wilbur Missouri — DATE OF BURIAL: 9-21 1920

20. UNDERTAKER: G E Thompson — ADDRESS: Gooding Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31744 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
File No. .....
Registered No. 30

2. FULL NAME Clarence G Knox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
March (Month) 24 (Day) 1904 (Year)

7. AGE
16 Yrs. 6 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Student
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Grangeville

10. NAME OF FATHER: John Knox

11. BIRTHPLACE OF FATHER
(State or Country) ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER
(State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Knox
(Address) Grangeville

15.
Filed Oct 1 1920 G S Stockton
Local Registrar

BYRNE - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-16 1920, to 9-26 1920, that I last saw him alive on 9-21 1920, and that death occured on the date stated above, at 10:30 P M.

The CAUSE OF DEATH* was as follows:
Concussion due to fall from wagon

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary) .....

.....(Duration .....yrs. .....mos. .....ds.

(Signed) B C Chapman M. D.
9/26 1920 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Sept 23 1920

20. UNDERTAKER: J J Mauzy — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31745

Registered No. 29

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Willey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) 10 (Day) 1907 (Year)

7. AGE: 12 Yrs. 1 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Studedit
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Grangeville

10. NAME OF FATHER: Geo. Willey

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Edith Wright

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Willey
(Address) Grangeville

15. Filed Oct 1 1920 G B Stockton Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw ..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) A J Mangy M. D.
7/12 1920 (Address) Grangeville

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: July 12 1920

20. UNDERTAKER: A J Mangy — ADDRESS: City.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1001
(No. ..... , ... St.)

File No. 31746
Registered No. 28

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Asa Samuel Wright
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.: Oct (Month) 10 (Day) 1860 (Year)

7. AGE: 59 Yrs. 8 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Grocer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kentucky

10. NAME OF FATHER: Benjamin F Wright

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Willey
(Address) Grangeville Idaho

15.
Filed Oct 1 1920
G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw ... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A J Mauzy M. D.
7/12 1920 (Address) Coroner.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie View
DATE OF BURIAL: July 12 1920

20. UNDERTAKER: A J Mauzy
ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SOBS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 49

Primary Registration District No. 1419

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31747

Registered No.

1. PLACE OF DEATH

County of Idaho

City of Near Kamiah Ida

If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Letitia Parsons

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Indian	Married

6. DATE OF BIRTH: Nov (Month) 4 (Day) 1880 (Year)

7. AGE: 39 Yrs. 10 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James Hayes

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Jamie Daily

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Paul F. Corbett

(Address)

15. Filed 9/6 19 20 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 5 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4th 19 20, to Sept 5th 19 20, that I last saw he alive on Sept. 5th 19 20, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Placenta Previa
(complete)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. S. Bryce M. D.

Sept 6 1920 (Address) Kamiah, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ind Cem No 1. DATE OF BURIAL: Sept 7 19 20

20. UNDERTAKER: C J Johnson ADDRESS: Kamiah Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

File No. 31748

County of Idaho

City of Grangeville (No. ....., ... St.)

Registered No. 27

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. November (Month) 2d (Day) 1832 (Year)

7. AGE: 87 Yrs. 10 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Cleaveland Ohio

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER — (State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER — (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo. Smith

(Address) Byles Idaho

15.

Filed Oct 1 1920

G. S. Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1920, to Aug. 1920, that I last saw h... alive on Aug 28 1920 and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) B. O. Thompson M. D.

9/30 1920 (Address) Grangeville Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: 9-28 1920

20. UNDERTAKER: E. S. Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 21750
Registered No. 23

1. PLACE OF DEATH
County of Idaho
City of Mt Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103
Primary Registration District No. 2181
(No. ..... St.)

2. FULL NAME Ira Ray Hindman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Nov (Month) 30th (Day) 1905 (Year)

7. AGE: 14 Yrs. 7 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Mt Idaho

10. NAME OF FATHER: Ira Hindman

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Jane Arp.

13. BIRTHPLACE OF MOTHER (State or Country): Benton Co Arkansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Hindman
(Address) Mt Idaho

15. Filed Oct 1 1920 G S Stockton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Common Carotid Artery severed by fish steel

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B Chipman M. D.
7/17 1920 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt Idaho
DATE OF BURIAL: July 17 1920

20. UNDERTAKER: E S Hancock
ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 21751

Registered No. 24

1. PLACE OF DEATH

County of Idaho

Registration District No. 103

Primary Registration District No. 2181

City of Driggs Mt Idaho (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mason Evan Hindman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: March (Month) 2d (Day) 1844 (Year)

7. AGE: 76 Yrs. 5 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Marlinsville West Virginia

10. NAME OF FATHER: Francis Hindman

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E H Hindman
(Address) Mt Idaho

15. Filed Oct 1 1920 G S Stocklin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920 to July 10 1920 that I last saw him alive on July 9 1920 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arterio-Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stocklin M. D.

7/17 1920 (Address) Grangeville

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mt. Idaho Id — DATE OF BURIAL: July 11 1920

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

31752

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 926
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 105
Primary Registration District No. 2183
(No. ....., ... St.)

1. PLACE OF DEATH
County of Idaho
City of Ferdinand
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cletus Edward Maus

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 29 (Day) 1915 (Year)

7. AGE: 4 Yrs. 9 Mos. 11 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Co

10. NAME OF FATHER Albert Maus

11. BIRTHPLACE OF FATHER (State or Country) Minnesota

12. MAIDEN NAME OF MOTHER Frances Kuther

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert Maus
(Address) Ferdinand I. Co. Ida.

15. Filed Sept 9 1920
H. H. Blake
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1920 to Sept 9 1920
that I last saw him alive on Sept 9 1920
and that death occurred on the date stated above, at 1.2.4 M.

The CAUSE OF DEATH* was as follows:
Diptheria
.....
.....
.....(Duration) ..... Yrs..... mos. 9 ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) J. D. Shinnick M. D.
Sept 9. 1920 (Address) Cottonwood Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Ferdinand Ida. DATE OF BURIAL 9-9 1920

20. UNDERTAKER A. H. Maus ADDRESS Cottonwood

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31753

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 105

Primary Registration District No. 2183

File No. 27

County of Idaho

City of Cottonwood

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia Gentry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Nov (Month) 20 (Day) 1890 (Year)

7. AGE: 29 Yrs. 9 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. D.

10. NAME OF FATHER: Peter Klapprich

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Mary Herbolind

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Peter Klapprich

(Address) Cottonwood Idaho

15.

Filed Sept 16th 1920

H B Blake, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1920, to Sept 16 1920, that I last saw her alive on Sept 16 1920, and that death occured on the date stated above, at 5:25 A. M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

following childbirth

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H B Blake M. D.

9/16 1920 (Address) Cottonwood

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cottonwood Idaho — DATE OF BURIAL: 9-17 1920

20. UNDERTAKER: A H Nau — ADDRESS: Cottonwood Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 1017-2017
File No. 31755
Registered No.

1. PLACE OF DEATH
County of Jerome
City of Eden
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Conn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (or widower)
6. DATE OF BIRTH: June (Month) 29 (Day) 1840 (Year)
7. AGE: 79 Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country) Ohio
10. NAME OF FATHER George Croft
11. BIRTHPLACE OF FATHER (State or Country) Ga.
12. MAIDEN NAME OF MOTHER Mary Simon
13. BIRTHPLACE OF MOTHER (State or Country) Ga.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. O. Rowe
(Address) Eden Idaho
15. Filed Sept 18 1920 E. D. Pyper M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1920 to May 8 1920 that I last saw her alive on May 8 1920, and that death occurred on the date stated above, at 11 3/4 M.
The CAUSE OF DEATH* was as follows:
Terminal lobar pneumonia following old chronic progressive heart lesions and nephritis
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Nephritis organic heart.
(Duration) 10-15 yrs. ..... mos. ..... ds.
(Signed) E. L. Berry M. D.
5-10 1920 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL ..... 19.....
20. UNDERTAKER: J. P. Grossman — ADDRESS Twin Falls

Berry

RM V. S. No. 5-25 M. 1-16-[illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. [illegible]

Registered No. [illegible]

PLACE OF DEATH.

County of Kootenai

City of Worley. (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Hanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. Aug. (Month) 23 (Day) 1847 (Year)

7. AGE: 73 Yrs. X Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway.

10. NAME OF FATHER: Herbrand Hanson

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Martha Margretta Brandt

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Albert Hanson

(Address) Worley, Ida.

15. Filed Sept. 25 1920

H. A. Jaegers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~ 191..., to ~ 191..., that I last saw h~ alive on ~ 191..., and that death occured on the date stated above, at ~ M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (Supposed)

Hour of Death.

(Duration) ~ Yrs. ~ mos. ~ ds.

Contributory (Secondary)

(Duration ... yrs. ... mos. ... ds.

(Signed) L. Celanton M. D.

9/24 1920 (Address) Rockford Ill

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Worley. Idaho — DATE OF BURIAL: Sept. 27 1920

20. UNDERTAKER: H. A. Jaegers — ADDRESS: Plummer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31757 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1031
File No.
Registered No. 836

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. Blackwell Add St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margret Morrock

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 18 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Jack Morrock

11. BIRTHPLACE OF FATHER (State or Country): Poland

12. MAIDEN NAME OF MOTHER: Julia Kuliciuscia

13. BIRTHPLACE OF MOTHER (State or Country): Hungaria

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Morrock
(Address):

15. Filed Oct 4 1920 D D Drema
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1920, to Aug 27 1920
that I last saw h[er] alive on Aug 27 1920,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Acute intestinal toxemia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. Thayer M. D.
1 19 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Coeur d'Alene
DATE OF BURIAL: 8-29 1920

20. UNDERTAKER: C. Cassedy
ADDRESS: C D'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 31758
Registered No. 833

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 314 Gordon St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Blackburn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1847 (Year)

7. AGE: 73 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Janitor
(b) General nature of industry, business or establishment in which employed (or employer): Coeur d'Alene Bank & Trust

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Blackburn

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Miss Arnold

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harold Purdy
(Address) Coeur d'Alene Ida

15. Filed Oct 4 1920 T. D. Drema Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19..., to — 19...,
that I last saw h— alive on — 19...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Apoplexy. Sudden —

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Gastritis
..... (Duration) ..... yrs. — mos. 10 ds.
(Signed) J. H. Holden M. D.
7/31 1920. (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 14 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Aug 2 1920
20. UNDERTAKER: R B Mooney — ADDRESS: Cda Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30[illegible]
Primary Registration District No. [illegible]1031
File No. 31759
Registered No. 837

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. Dalton Gardens St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert E Frutig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 8 (Day) 1883 (Year)

7. AGE: 35 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Benoit Frutig

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Albert Frutig
(Address) Coeur d Alene Ida

15. Filed Oct 4 1920 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug. (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 6 A. M.
The CAUSE OF DEATH* was as follows:

Poisoned by Carbolic acid - Suicide

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Owyn M. D.
Aug. 28 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 4y yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Jantine

19. PLACE OF BURIAL OR REMOVAL: Detroit Mich
DATE OF BURIAL: Sept 1920

20. UNDERTAKER: C B Mooney
ADDRESS: Coeur d'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 3760
Registered No. 838

1. PLACE OF DEATH
County of Kootenai
City of Coeur d Alene (No. Coeur d Alene Trailer St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tommy Wyatt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: About (Month) (Day) 1 (Year)

7. AGE: 35 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fire Fighter
(b) General nature of industry, business or establishment in which employed (or employer): Forest Service C d A

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Coeur d Alene Trailer
(Address) Coeur d Alene Idaho

15. Filed Oct 4 1920 D D Dreman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 28 1920 to Sep. 3. 1920 that I last saw him alive on Sep. 3. 1920 and that death occurred on the date stated above, at 1.30 P.M.

The CAUSE OF DEATH* was as follows:
General peritonitis.

(Duration) Yrs. mos. 6. ds.
Contributory (Secondary) Perforated gastric and duodenal ulcers.
(Duration) yrs. mos. 6 ds.

(Signed) John O Wood M. D.
Sep. 3 1920 (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. 14 days
Where was disease contracted if not at place of death?
Former or usual residence Spokane, Wn.

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: Sept 6. 1920

20. UNDERTAKER: C F Mooney
ADDRESS: Coeur d Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 31761
Registered No. 839

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. Coeur d'Alene Hospital)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Bell Barnum
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Married, Widowed, Divorced)

6. DATE OF BIRTH: Sept (Month) 3 (Day) 1920 (Year)

7. AGE: ___ Yrs. ___ Mos. ___ ds.
IF LESS than 1 day how many 6 hrs. or ___ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ___
(b) General nature of industry, business or establishment in which employed (or employer): ___

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. J. Barnum

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Belle Hall

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W J Barnum
(Address) Coeur d'Alene

15. Filed Oct 4 1920 DD Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 2 1920, to Sept. 3 1920
that I last saw her alive on Sept. 3 1920
and that death occurred on the date stated above, at 7a M.
The CAUSE OF DEATH* was as follows:
Uremia and premature birth. 7 mo.

(Duration) ___ Yrs. ___ mos. 1 ds.
Contributory (Secondary) Eclampsia (Maternal)
(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) John Olwood M. D.
Sept 7 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ___ yrs. ___ mos. ___ days. In the State ___ yrs. ___ mos. ___ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Sept 4 1920

20. UNDERTAKER: [illegible] — ADDRESS: 113 Mooney Coeur d'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1031
File No. 31762
Registered No. 840

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 1011 Indiana St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel Elliott
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: 8 (Month) 28 (Day) 1880 (Year)

7. AGE: 40 Yrs. 0 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician Teacher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: John Clyne

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: — Boldyer

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo A Elliott
(Address) Coeur d Alene Idaho

15. Filed Oct 7 1920 D D Dreman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1920 to Sept 6 1920 that I last saw h[illegible] alive on Sept 6 1920 and that death occurred on the date stated above, at 12.30 a. M.
The CAUSE OF DEATH* was as follows:

1. Thrombosis of Pulmonary artery
(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) T H Scallon M. D.
1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: C D Alene St. Thomas — DATE OF BURIAL: Sept. 7 1920

20. UNDERTAKER: C. Carney — ADDRESS: C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 80
Primary Registration District No. 1051
File No. 21762
Registered No. 849

1. **PLACE OF DEATH**
County of Kootenai
City of Coeur d Alene
(No. 727 Front St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Jennie B Thomas
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female
4. **COLOR OR RACE** White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.) Single

6. **DATE OF BIRTH** June (Month) 3 (Day) 1905 ~~1900~~ (Year)

7. **AGE** 2 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. **BIRTHPLACE** (State or Country) So Dakota

10. **NAME OF FATHER** J B Thomas

11. **BIRTHPLACE OF FATHER** (State or Country) Iowa

12. **MAIDEN NAME OF MOTHER** Nora Perry

13. **BIRTHPLACE OF MOTHER** (State or Country) Iowa

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) J B Thomas
(Address) Coeur d Alene Ida

15. Filed Oct 4 1920 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Sept (Month) 2 (Day) 19 20 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Aug 1 19 20 to 19 .....
that I last saw h. w. alive on Sept 2 1920
and that death occurred on the date stated above, at 12 30 M.
The CAUSE OF DEATH* was as follows:

Sarcoma

(Duration) — Yrs. 6 mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M D
Sept 2 1920 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. 3 mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence White Lake So Dak

19. **PLACE OF BURIAL OR REMOVAL** White Lake So Dak — **DATE OF BURIAL** Sept 3 1920

20. **UNDERTAKER** C B Mooney — **ADDRESS** Coeur d Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 31766
Registered No. 848

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 102 Indiana St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Carl Clifford Osland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: June (Month) 16 (Day) 1820 (Year)

7. AGE: 0 Yrs. 3 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Carl Osland

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Bessie Mooney

13. BIRTHPLACE OF MOTHER (State or Country): Minn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl J. Olslund
(Address) 102 Indiana

15. Filed Oct 4 1920 D D Drenna
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 16 1920, to Sept 16 1920
that I last saw him alive on Sept 16 1920
and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:
Double Pneumonia (Broncho)

(Duration) Yrs. ..... mos. 1 ds.
Contributory (Secondary) Malnutrition
(Duration) yrs. 3 mos. ..... ds.

(Signed) J. H. Holden M. D.
9/17 1920. (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: C'Dalene
DATE OF BURIAL: 9-16 1920

20. UNDERTAKER: C. Casseday
ADDRESS: C'Dalene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1031

(No. ..... St.)

File No. 31767

Registered No. 844

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel A Snyder

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 27 (Day) 1869 (Year)

7. AGE: 50 Yrs. 8 Mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Helpless for a number of years
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Wm Snyder

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Barbara Nelto

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J E Snyder
(Address) Coeur d'Alene, Ida

15. Filed Oct 4 1920 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1918, to Sept 19 1920 that I last saw him alive on Sept 19 1920 and that death occurred on the date stated above, at 6:30 M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 20 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) D D Drenna M. D.

9/29 1920 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 30 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	Sept 21 1920

20. UNDERTAKER: C B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 31768
Registered No. 843

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene. (No. 204 Garden St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Walter Leeper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widower (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 16 (Day) 1867 (Year)

7. AGE: 52 Yrs. 9 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real estate
(b) General nature of industry, business or establishment in which employed (or employer): and Insurance

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: —— Leeper

11. BIRTHPLACE OF FATHER (State or Country): Ken.

12. MAIDEN NAME OF MOTHER: Emily Ashby

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt T Leeper
(Address) Coeur d'Alene Idaho

15. Filed Oct 7 1920 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1919 19..., to Sep. 26 1920
that I last saw him alive on Sep. 26 1920
and that death occurred on the date stated above, at 1a M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O Wood M. D.
Sep. 27 1920 (Address) Coeur D'Alene. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston. Ida.
DATE OF ~~BURIAL~~ removal: 9-28 1920

20. UNDERTAKER: C. Cassedy
ADDRESS: C'Dalene. Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 31769
Registered No. 846

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene No. 228 Davidson St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. W. Hodge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 10 (Day) 1843 (Year)

7. AGE: 77 Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ver.

10. NAME OF FATHER: Russell Hodge

11. BIRTHPLACE OF FATHER (State or Country): Ver.

12. MAIDEN NAME OF MOTHER: Jane Perkins

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maria C. Hodge
(Address) Coeur d'Alene Ida

15. Filed Oct 4 1920 D D Dreman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep. 26 1920, to Sep. 27 1920 that I last saw him alive on Sep. 26 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Epithelioma of face.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Olwood M. D.
Sep. 28 1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. C'd'Alene
DATE OF BURIAL: 9-29 1920

20. UNDERTAKER: C. Cassedy
ADDRESS: C'd'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH. 31770

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
(No. ..... St.)

File No. 3
Registered No. 65

1. PLACE OF DEATH.
County of Kootenai
City of Hauser
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mildred Elaine Honsowetz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. May (Month) 21 (Day) 1920 (Year)

7. AGE ..... Yrs. 3 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Wm Honsowetz

11. BIRTHPLACE OF FATHER (State or Country) Wisc

12. MAIDEN NAME OF MOTHER Celia Johnson

13. BIRTHPLACE OF MOTHER (State or Country) Wisc

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Honsowetz
(Address) .....

15. Filed Oct 1 1920 J M Feeney Local Registrar

SYMS - YORK CO., PTRS. & BOXES. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31 1920 to Sept 2 1920 that I last saw h[illegible] alive on Sept 2 1920 and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows: Gastro Enteritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... Duration ..... yrs. ..... mos. ..... ds.

(Signed) J M Feeney M. D.
9-3 1920 (Address) Hauser Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hauser — DATE OF BURIAL: 9-3 1920

20. UNDERTAKER: Thom — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

1. [redacted] District No. 61

[redacted] ration District No. 2111

City of Farmington (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Euphena Kerr

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31771

Registered No. 121

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Oct. (Month) 18 (Day) 1857 (Year)

7. AGE: 62 yrs. 10 mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: Henry Pribbles

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Sarah E. Rohmicke

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Elizabeth English
(Address) .....

15. Filed Sept 30 1920 W. H. Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1920, to Sept 17 1920 that I last saw her alive on Sept 14 1920 and that death occurred on the date stated above, at 1130 M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

..... (Duration) — yrs. — mos. 7 ds.

Contributory Cardio sclerosis

(Secondary) ..... (Duration) Years yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Sept 18 1920 (Address) P. E. Beal

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: F. L. G. Farmington — DATE OF BURIAL: ..... 191...

20. UNDERTAKER: F. L. Irwin — ADDRESS: Garfield, Wash

SYMS-YORK CO., PRINTERS-BINDERS, BOISE 17148

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31772

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No.

Registered No. 118

1. PLACE OF DEATH

County of Latah

City of Moscow

(No. Pullman Hospital St.)

Registration District No. 61

Primary Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Florence Parog

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: W. Cauc.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Sing

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1904 (Year)

7. AGE: 13 Yrs. 4 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Leon E. Parog

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Rachel Desvoignes

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Rachel Parog

(Address) Pullman Wash

15. Filed 9/-3 1920 W. T. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31 1920, to Sept 3 1920, that I last saw h[illegible] alive on Sept 3 1920 and that death occurred on the date stated above, at 11:25 A. M.

The CAUSE OF DEATH* was as follows:

Septicemia - Pen - tonsillar abscess -

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. L. Estes M. D.

9/3 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. 3 days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Pullman Idaho

19. PLACE OF BURIAL OR REMOVAL: Pullman Idaho

DATE OF BURIAL: 9/5 1920

20. UNDERTAKER: Elm Grove

ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMONDS PRINTING CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31773

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 101
Primary Registration District No. 1011
File No.
Registered No. 119

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Henry Witham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: July (Month) 27 (Day) 1842 (Year)

7. AGE: 78 Yrs. 1 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mechanic.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Hampshire

10. NAME OF FATHER: John P Witham

11. BIRTHPLACE OF FATHER (State or Country): Milton. New Hampshire

12. MAIDEN NAME OF MOTHER: Elizabeth L. Witham

13. BIRTHPLACE OF MOTHER (State or Country): Avon Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Jones
(Address) Moscow

15. Filed 9/9 1920 W. H. Carruthers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 6 1920, to Sept 8 1920, that I last saw h.m alive on Sept 6 1920, and that death occurred on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic valvular Heart disease.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. H. Carruthers M. D.

9/9 1920 (Address) Moscow Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	9/10 1920
20. UNDERTAKER Glen Price	ADDRESS Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 10 11
File No. 31274
Registered No. 120

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gunder T. Hoseid.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Feb (Month) 14 (Day) 1872 (Year)

7. AGE: 48 Yrs. 6 Mos. 25 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Thor Hoseid

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: Karen Marie Hoseid

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gunder Hoseid
(Address) Moscow Idaho

15. Filed 9/11 1920 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-3-1920 to 9-9-1920 that I last saw h~~im~~ alive on 9-9-1920 and that death occurred on the date stated above, at 4:35 PM

The CAUSE OF DEATH* was as follows:

Diaphragmatic Hernia,

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Traumatism

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Charles L. Gilman M. D.

9/11 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: Sept 14 1920

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

31775

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... St.)
File No. .....
Registered No. 122

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha J Reeder
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 13 (Day) 1857 (Year)

7. AGE: 63 Yrs. 3 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Abraham Pratt

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Shaffer

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. H. Reeder
(Address) Moscow

15. Filed 9/20 19.....
W. H. Carithers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14 1920, to Sept 18 1920, that I last saw her alive on Sept 17 1920, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Slight attack 4 years ago

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Edwards M. D.

9/20 19..... (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 9/20 1920

20. UNDERTAKER: Edwards | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2142
File No. 3177
Registered No. 2

1. PLACE OF DEATH.
County of Latah
City of Genesee (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Boyle

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Feb 1 1847
(Month) (Day) (Year)

7. AGE 73 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Guelph Canada

10. NAME OF FATHER: Henry Foster

11. BIRTHPLACE OF FATHER (State or Country): Irland

12. MAIDEN NAME OF MOTHER: ~~Mary Foster~~ Mary Hopkins

13. BIRTHPLACE OF MOTHER (State or Country): Irland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thos Foster
(Address) Genesee

15. Filed 9-9 1920 W. F. Green
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 8th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2nd 191..., to Sept 8th 1920, that I last saw her alive on Sept 3rd 1920, and that death occured on the date stated above, at 7:55 P. M.

The CAUSE OF DEATH* was as follows:

Sclerosis of Liver

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. F. Harris M. D.
9-8 1920 (Address) Colton Wn

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho — DATE OF BURIAL: 9-10 1920

20. UNDERTAKER: F. E. Lambert — ADDRESS: Genesee

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STERN - WEBB CO., PTRS. & BKBS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2142
File No. 31778
Registered No. 2

1. PLACE OF DEATH.
County of Latah
City of Genesee
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Oscar Canham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. 1 (Month) 21 (Day) 1868 (Year)

7. AGE 52 Yrs. 8 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farming
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) N. S.

10. NAME OF FATHER John Canham

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) N. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Ethel Canham
(Address) Moscow Ida

15. Filed Oct. 30 1920 W. F. Kleeb Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 9 (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-29-20 191..., to 9-29-20 191..., that I last saw h... alive on 9- 191..., and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:
Hemorrhage - following bleeding
Left inner thigh - fell in
front of disc plow

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration ... yrs. ... mos. ...

(Signed) H. H. Ponsee M.D.
9-29 1920 (Address) Genesee - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow - Idaho — DATE OF BURIAL: 9 30 1920

20. UNDERTAKER: Glenn Grice — ADDRESS: Moscow Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 31779
Registered No.

1. PLACE OF DEATH
County of Latah
City of Troy.
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leslie Byers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Sept- (Month) 17 (Day) 1919 (Year)

7. AGE: 1 Yrs. Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none -
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Troy,

10. NAME OF FATHER: Joseph E. Byers.

11. BIRTHPLACE OF FATHER (State or Country): Troy Idaho

12. MAIDEN NAME OF MOTHER: Lucy Holden

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Sarah A Byers
(Address) Troy Idaho

15. Filed Oct 7 1920 J. E. Pickerd
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct- (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept- 21 1920, to Sept-29 1920 that I last saw h-im- alive on Sept-29 1920, and that death occurred on the date stated above, at 7 30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Gastroenteritis

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) Sublingual abscess

(Duration) yrs. mos. 4 ds.

(Signed) Miles Hopkins M. D.

19 (Address) Troy Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bnal — DATE OF BURIAL: Oct 12 1920

20. UNDERTAKER: J E Pickerd — ADDRESS: Troy

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 64

Primary Registration District No. 2144

(No. .... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31780

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah

City of Troy

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Smucker.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH.

Nov. (Month) 14 (Day) 1866 (Year)

7. AGE

53 Yrs. 10 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.? —

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: E C Taylor

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Manda Mecum

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Mrs. Smucker

(Address) Troy Idaho

15.

Filed Sept 23 1920

J. E. Pickerd
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1919, to Sept 16 1920 that I last saw h.. alive on Sept 16 1920 and that death occured on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Ulceration of Bowels.
Causing Exhaustion

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) Heart Knew

(Duration 2 yrs. mos. ds.

(Signed) C. K. Henkle M. D.

1920 (Address) Troy Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Idaho

DATE OF BURIAL: Sept 23 1920

20. UNDERTAKER: J E Pickerd

ADDRESS: Troy

FORM V. S. No. 5-12 M. 6-15-17.

31783

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 41
Primary Registration District No. 2716
File No. .....
Registered No. .....

1. PLACE OF DEATH
County of Lewis
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH May 8th 1876
(Month) (Day) (Year)

7. AGE 44 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Quartz Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Carl E. Anderson

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Caroline Sutherland

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. J. Anderson
(Address) Rupert, Ida.

15.
Filed ..... 191....
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1920 to Sept 12 1920
that I last saw him alive on Sept 12 1920
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Acute Bright Disease
(Acute Nephritis)
(Duration) ..... Yrs. ..... mos. One Hour ds.

Contributory (Secondary) Asthma Contributory
(Duration) ..... Yrs. ..... mos. One Hour ds.

(Signed) ..... M. D.
9/13 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery — DATE OF BURIAL 9-16 1920

20. UNDERTAKER W. C. Jacobs — ADDRESS Salmon Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31784

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of [redacted] Lincoln
City of Shoshone
(No. ..... St.)

Registration District No. 57
Primary Registration District No. 2022
File No. .....
Registered No. 38

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sadie Higdon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. June 22 1852 (Month) (Day) (Year)

7. AGE: 68 Yrs. 2 Mos. 17 ds.
IF LESS than 1 day how many .....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Maine.

10. NAME OF FATHER: Wm. Ireland.

11. BIRTHPLACE OF FATHER (State or Country): Maine.

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) x Chas. A. Higdon
(Address) Bellevue, Idaho.

15. Filed 9-10 1920 P. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 9- 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1920, to Sept 9 1920, that I last saw h[illegible] alive on Sept 9 1920, and that death occured on the date stated above, at 1 11 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Colitis

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —
(Duration) yrs. mos. ds.

(Signed) R. Lewis Hawkins M. D.
Sept 10 1920 (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon City, Colo.
DATE OF BURIAL: — 191...

20. UNDERTAKER: P. D. Harris
ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

31785

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 7
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lemhi
City of Leadore
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 42
Primary Registration District No. 2153
(No. ....., ... St.)

2. FULL NAME Mrs. Louise Dry

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Nov (Month) 12 (Day) 1871 (Year)

7. AGE: 48 Yrs. 10 Mos. 15 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Elijah L Foster

11. BIRTHPLACE OF FATHER (State or Country): X

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (State or Country): X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Geo B Hansen
(Address) Leadore Ida

15. Filed 10/1/ 1920 I B Keller
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/24 1920 to 9/28/ 1920
that I last saw her alive on 9/28/ 1920
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:

a general Peritonitis

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Do not know
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Irvin B. Keller M. D.
10/1/1920 (Address) Leadore, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Junction Cemetery — DATE OF BURIAL: 9/29/ 1920

20. UNDERTAKER: W. C. Doubler — ADDRESS: Salmon, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31786

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20

Primary Registration District No. 2129

File No.

Registered No. 16

1. PLACE OF DEATH

County of Shoshone

City of Wardner

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vincent S. Huber

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct. (Month) 11 (Day) 1892 (Year)

7. AGE: 27 Yrs. 10 Mos. 24 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Jacob A. Huber

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elizabeth Mueller

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob A. Huber

(Address) Dan Zed Bremerton, Wash.

15. Filed 9/7 1920 P. G. Dunlap M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 4 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 21, 1920, to Sept. 4, 1920 that I last saw h.im alive on Sept. 4, 1920, and that death occurred on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) — Yrs. — mos. 21 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) John J. Darby M. D.

9-6-1920 (Address) Craigmont, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: IOOF Cemetery — DATE OF BURIAL: 9/8 1920

20. UNDERTAKER: Stockham Furn Co — ADDRESS: Craigmont

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 3428
(No. ..... St.)

File No. 31787
Registered No. .....

1. PLACE OF DEATH.
County of .....
City of .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agha Hanger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. June 18 (Month) (Day) 1919 (Year)
7. AGE: 1 Yrs. 3 Mos. 1 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: James Hanger
11. BIRTHPLACE OF FATHER (State or Country): No Carolina
12. MAIDEN NAME OF MOTHER: Annie Osborn
13. BIRTHPLACE OF MOTHER (State or Country): Kentucky
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Robert L. Hanger
(Address) Kamiah Ida
15. Filed 9/20 1920
C J Johnson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 19 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept. 18 1920, to Sept. 19th 1920, that I last saw h[illegible] alive on Sept. 19th 1920, and that death occured on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:
Cerebral Colitis
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) A. J. Bryan M. D.
Sept 20 1920 (Address) Kamiah, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [redacted] Cem. Kamiah — DATE OF BURIAL: 9/20 1920

20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

Registration District No. 16

Primary Registration District No. 1016

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31789

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lincoln

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence L. Dressler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec 29 1889 (Month) 1889 (Day) 1 (Year)

7. AGE: 30 Yrs. 9 Mos. 8 ds. 27

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Shoshone Idaho

10. NAME OF FATHER: O J Brennan

11. BIRTHPLACE OF FATHER (State or Country): Penna USA

12. MAIDEN NAME OF MOTHER: Alice J Keefer

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O J Brennan

(Address) Shoshone Idaho

15. Filed Sept 27 1920

Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 27 1920, to Sept 27 1920, that I last saw h.e. alive on Sept 26 1920 and that death occured on the date stated above, at 5 a. M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(Duration) 1 Yrs. 1 mos. — ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Baugh M. D.

19..... (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone Idaho — DATE OF BURIAL: 9-28 1920

20. UNDERTAKER: O J Brennan — ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31791 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
(No. ....., ... St.)
File No. 76
Registered No. .....

1. PLACE OF DEATH.
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorenz Redford Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. P.P. January (Month) 29 (Day) 1920 (Year)

7. AGE: ..... Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John R. Clark

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nora Redford

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): John R. Clark
(Address): Rexburg

15. Filed 10/2 1920
G. E. Cope
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1920, to Sept 30 1920, that I last saw h— alive on Sept 30 1920 and that death occured on the date stated above, at 4:50 A.M.
The CAUSE OF DEATH* was as follows:
Typhoid Meningitis
..... (Duration) ..... Yrs. 1 2 mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. Haeser M. D.
19 ..... (Address) Rexburg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rexburg, Idaho — DATE OF BURIAL: Oct 3 1920

20. UNDERTAKER: John M. Richards — ADDRESS: Rexburg Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 31792

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 75

Registered No.

1. PLACE OF DEATH

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julian Bernard Jennings

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: November (Month) 3 (Day) 1902 (Year)

7. AGE: 17 Yrs. 10 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Julian A. Jennings

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Rebecca B. Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. Alma Johnson

(Address) Burton, Ida.

15. Filed 9/20 1920

G. L. Espe
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) 18th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/14 1920, to 9/18 1920, that I last saw h[illegible] alive on 9/18 1920, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Accidental gunshot

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. L. Espe M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton, Idaho

DATE OF BURIAL: Sep. 21 19 20

20. UNDERTAKER: John Phillips

ADDRESS: Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

31793

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 2178
File No. 14
Registered No.

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME P. R. Hulet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. September (Month) 15 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
If LESS than 1 day how many 2 hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Rexburg, Idaho

10. NAME OF FATHER P. R. Hulet

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Ella M Corey

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. M. Corey
(Address) Rexburg Idaho

15. Filed 9/15 1920 G. L. Espe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH September (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1920 to Sept 15 1920, that I last saw her alive on Sept 15 1920, and that death occured on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Premature Birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) Carley Nelson M. D.
9-15 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burton, Idaho
DATE OF BURIAL: Sept. 15 1920

20. UNDERTAKER: John M. Richards.
ADDRESS: Rexburg Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31794

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 13

Registered No.

1. PLACE OF DEATH

County of Madison

City of Independence (No. ..... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Christiansen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: January (Month) 30 (Day) 1835 (Year)

7. AGE: 85 Yrs. 7 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Blacksmith

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Christian Christoferson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Christena Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Eugene Smith

(Address) Rexburg RD #1

15. Filed 9/28 1920

G G Kespe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/25 1920 to 9/27 1920 that I last saw h.... alive on 9/25 1920 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

General debility

..... (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G G Parkinson M. D.

..... 19..... (Address) Rexburg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lyn's Utah

DATE OF BURIAL: 9/30 1920

20. UNDERTAKER: John Phillips

ADDRESS: Rexburg

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

Martin

31795

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 10
Primary Registration District No. 2178
(No. ..... St.)

File No. 7
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of .....

City of .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William B Jensen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH. Sept 7 1908
(Month) (Day) (Year)

7. AGE 11 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ruby Idaho

10. NAME OF FATHER A B Jensen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Isabell Smith

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isabell Jensen
(Address) Ruby

15. Filed Aug 26 1920 G G Gesler
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 25 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1920 to Aug 24 1920 that I last saw him alive on Aug 24 1920 and that death occurred on the date stated above, at 4:30 A.M.

The CAUSE OF DEATH* was as follows:
Basal Fracture
.....
.....
.....(Duration) .... Yrs. .... mos. 1 ds.

Contributory (Secondary) Hemorrhage
.....(Duration) .... Yrs. .... mos. 1 ds.

(Signed) A L Martin M. D.
Aug 26 1920 (Address) Ruby Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ruby	8/29 1920
20. UNDERTAKER	**ADDRESS**
J Ryan	Ruby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100 — 31796 — File No. 71.

Primary Registration District No. 2178 — Registered No.

1. PLACE OF DEATH

County of Madison

City of (No. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo. B. Chambers.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, ~~WIDOWED OR DIVORCED~~ (Write the word.)
Male	White	married

6. DATE OF BIRTH: December (Month) 25 (Day) 1885 (Year)

7. AGE: 34 Yrs. 8 Mos. ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Accountant for C W M Co.

(b) General nature of industry, business or establishment in which employed (or employer): Book keeper for C W M Co.

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Frank Chambers

11. BIRTHPLACE OF FATHER (State or Country): U.S.A.

12. MAIDEN NAME OF MOTHER: Sarah Brower

13. BIRTHPLACE OF MOTHER (State or Country): U.S.A.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Geo B Chambers

(Address) 718 9th Ave Salt Lake City Ut

15. Filed Aug 24 1920 — G J Kesler, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Accidental drowning

Coroners Verdict

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John B Phillips Coroner ~~M. D.~~

19..... (Address) Rexburg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake City Utah	19.....
20. UNDERTAKER: Perkins Furniture Co.	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

31797 Gooding

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19.
Primary Registration District No. 2015
File No.
Registered No. 53

1. PLACE OF DEATH
County of Minidoka
City of Minidoka
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elinas D Tatlow
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (~~Write the word.~~)

6. DATE OF BIRTH: Sept (Month) 21 (Day) 1845 (Year)

7. AGE: 74 Yrs. 11 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): " Ken

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Tatlow
(Address) Minidoka Idaho

15. Filed Sept 12 1920 — E. H. Elmore, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1919 19..., to Sept 6 1920 that I last saw h— alive on Sept 1 1920 and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. H. Evans M. D.
9-7-1920 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake — DATE OF BURIAL: Sept 8 1920

20. UNDERTAKER: H. G. Goodmeasure — ADDRESS: Rupert Idaho

FORM V. S. No. 5-25 M. 1-19.

31798 Elmore

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

File No. .....

Registered No. 54

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Francis M. McManus

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**

4. **COLOR OR RACE**

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.)

6. **DATE OF BIRTH** May (Month) 19 (Day) 1859 (Year)

7. **AGE** 61 Yrs. 3 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) England

10. **NAME OF FATHER** Wm. Jackson

11. **BIRTHPLACE OF FATHER** (State or Country) England

12. **MAIDEN NAME OF MOTHER** Fanny [redacted] Jackson

13. **BIRTHPLACE OF MOTHER** (State or Country) England

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Joseph McManus

(Address) Rupert Idaho

15. Filed Sept. 16 1920 E. H. Elmore Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Sept. (Month) 13 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from July 12 1920, to Sept 13 1920 that I last saw her alive on Sept. 11 1920, and that death occurred on the date stated above, at 7 P. M.

The **CAUSE OF DEATH*** was as follows:

Diffuse Carcinoma

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) Cancer of Uterus

(Duration) 2 Yrs. ..... mos. ..... ds.

(Signed) E. H. Elmore M. D.

9-16 1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Ogden Utah — **DATE OF BURIAL** Sept 18 1920

20. **UNDERTAKER** W. A. Goodman — **ADDRESS** Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 19 — 31799

Primary Registration District No. 2013

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia Minidoka

City of .....

If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

2. FULL NAME Julia Frean Linnell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Widow

6. DATE OF BIRTH. Aug. 11 1848 (Month) (Day) (Year)

7. AGE 72 Yrs. — Mos. 20 ds.

IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Unknown.

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Stillwell

(Address) Heyburn Ida.

15. Filed Oct. 3, 1920

E. H. Elmore per Mrs. Elmore
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug. 31 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...

that I last saw h... alive on Aug 31 1920

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Myocarditis

.....(Duration) Senile Yrs. ... mos. ... ds.

Contributory (Secondary) Senile Decay

.....(Duration) ... Yrs. ... mos. ... ds.

9/29 1920 (Signed) G. P. Smith M. D.

(Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the ,State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Burley Ida. **DATE OF BURIAL** Sept 4 1920

20. UNDERTAKER L. B. Tooley **ADDRESS** Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31800

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 19

Primary Registration District No. 205-0

File No.

County of Minidoka

City of Rupert (No. ..... St.)

Registered No. 56

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elmer E. Maynard.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.

June (Month) 2 (Day) 1869 (Year)

7. AGE

51 Yrs. / Mos. / ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Farmer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER Addison P. Maynard.

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Rhoda Berdine.

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. E. E. Maynard.

(Address) R.F.D. # 4. Rupert Ida.

15.

Filed ..... 191.....

E. N. Ware
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1920 to July 3 1920 that I last saw him alive on July 2 1920 and that death occured on the date stated above, at 8:45 A.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. V. Tilley M. D.

19..... (Address) Rupert Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn Ida. DATE OF BURIAL: July 7 1920

20. UNDERTAKER: L. B. Talboy. ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—[illegible] IS A PERMANENT RECORD. [illegible] should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGRS. 24655

FORM V. S. No.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1009

(No. Sisters Hospital St.)

File No. 31801

Registered No. 449

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cecelia Mc Dowell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Married

6. DATE OF BIRTH: Nov (Month) 15 (Day) 1882 (Year)

7. AGE: 38 Yrs. 10 Mos. 19 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Austria

10. NAME OF FATHER: John Hasenochel

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos McDowell
(Address)

15. Filed Sept 8 1920 — Roan E. Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 10 1920 to Sept 4 1920 that I last saw her alive on Sept 4 1920 and that death occurred on the date stated above, at 5-30 P.M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of Heart
Abscess of Rt. Kidney and
Sub phrenic abscess.
(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) (Post operative nephretomy) and as above
(Duration) yrs. 8 mos. ds.

(Signed) E. L. White M. D.
Sept 9 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mission — DATE OF BURIAL: Sept 6 1920

20. UNDERTAKER: W Blackmanson — ADDRESS: Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

or while

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31802

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. 108 16th ave St.)

File No.

Registered No. 450

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carl C Jeppesen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	married

6. DATE OF BIRTH: Mar (Month) 28 (Day) 1871 (Year)

7. AGE: 49 Yrs. 6 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Chris Jeppesen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Olive E. Jeppesen

(Address) .....

15. Filed Oct 8 1920 — Wm E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27 1920, to Sept 27 1920, that I last saw him alive on Sept 27 1920, and that death occurred on the date stated above, at 9:45 P.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach
Pneumonia, Stomach trouble
Contributory (Secondary) —

(Duration) 2 Mos Yrs. ..... mos. ..... ds.

(Signed) J B Morris M. D.

..... 19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: 1920

20. UNDERTAKER: W. B. Williamson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Morris

FORM V. S. No. 5-25 M. 1-19.

31803

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No.
Registered No. 457

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.
(No. St. Joseph Hospital St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugene A Crum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
m	w	Married

6. DATE OF BIRTH: Feb (Month) 6 (Day) 1 (Year)

7. AGE: 70 Yrs. 7 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): NY

10. NAME OF FATHER: R E Crum

11. BIRTHPLACE OF FATHER (State or Country): NY

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): NY

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. A. Crum
(Address) Yakima, Wash.

15. Filed Oct-8 1920 — Emma E. Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 29 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(Duration) 10 Yrs. mos. ds.
Contributory (Secondary) Syphilis
(Duration) 20 yrs. mos. ds.

(Signed) John N Alley M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Idaho	Oct-1 1920
20. UNDERTAKER	ADDRESS
W B Williamson	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

31804

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 95
Primary Registration District No. 1009
File No.
Registered No. 45-21

1. PLACE OF DEATH
County of Nez Perce
City of Culdesac
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H. M. Halsey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 31 (Day) 1871 (Year)

7. AGE: 48 Yrs. 11 Mos. ds. 8
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Hardware & Implement
(b) General nature of industry, business or establishment in which employed (or employer): Merchant

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: R. M. Halsey

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Lucy Young

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Halsey
(Address) Assotin Wash

15. Filed Oct-8 1920 Frank E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 - 1920, to Sept 9 - 1920, that I last saw him alive on Sept 9 - 1920, and that death occurred on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:
Automobile - accident

(Duration) Yrs. mos. 33 hours

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) George Garrison M. D.
Sept 9 1920 (Address) Culdesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wn. DATE OF BURIAL: Sept 11 1920

20. UNDERTAKER: Merchant ADDRESS: Clarkston Wn

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31805

Registered No. 453

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 95

Primary Registration District No. 333

(No. Naha Grade St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas Jelen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: April (Month) 25 (Day) 1877 (Year)

7. AGE: 43 Yrs. 4 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: John Jelen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Marion Metling

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Ruscator

(Address) Clarkston

15.

Filed ..... 19 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Auto accident

Fracture of Skull

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John V. Calley M. D.

19 ..... (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash

DATE OF BURIAL: Sept-1 1920

20. UNDERTAKER: Vassar Undertaking Co

ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31867

Registered No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH

County of Ada Canyon

City of Caldwell Ida. (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sherman Joseph Peer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 24 (Day) 1919 (Year)

7. AGE: 1 Yrs. 2 Mos. 16 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Sherman Peer

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: May B. Chitwood

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Sherman Peer

(Address) Caldwell Ida.

15. Filed Sept 9 1920 George Gaigneard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 — 1920, to Sept 9 — 1920, that I last saw him alive on Sept 9 — 1920 and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) Yrs. mos. 5 Weeks

Contributory (Secondary) Pneumonia

(Duration) yrs. mos. 6 ds.

(Signed) George Gaigneard, D.

Sept 10 1920 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida — DATE OF BURIAL: Sept 10 1920

20. UNDERTAKER: Merkley — ADDRESS: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31808
Registered No.

1. PLACE OF DEATH.
County of Nez Perce
City of Culdesac Ida.

Registration District No. 128
Primary Registration District No. Culdesac and Vicinity
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Ruth Johnston

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Aug (Month) 18 (Day) 1919 (Year)

7. AGE: one yrs. ..... mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George Johnston

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Lula Hepburn

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lula Johnston
(Address) Culdesac Idaho

15.
Filed Aug 1920 George Gaumard M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Aug (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 18 — 1920, to Aug 25 1920
that I last saw her alive on Aug 25 1920
and that death occurred on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

..... (Duration) ..... yrs. ..... mos. 3 Weeks ds.
Contributory (Secondary) Gastro-enteritis
..... (Duration) ..... yrs. ..... mos. 14 ds.

(Signed) George Gaumard M. D.
Aug 26 1920 (Address) Culdesac Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Culdesac Idaho
DATE OF BURIAL: Aug 26 1920

20. UNDERTAKER: George Johnston
ADDRESS: Culdesac Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2069
(No. ....., ... St.)

File No. 31809
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Boyd Evans.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 30 (Day) 1920 (Year)

7. AGE: ..... yrs. 3 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER James J. Evans

11. BIRTHPLACE OF FATHER (State or Country) Wales

12. MAIDEN NAME OF MOTHER Emma Williams

13. BIRTHPLACE OF MOTHER (State or Country) Cherry Creek, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James J. Evans
(Address) Malad, Idaho

15.
Filed Oct 1 1920
R. M. Maver M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Sept (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1st 1920 to Sept 13 1920
that I last saw him alive on Sept 13 1920
and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Whooping Cough
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. F. Allen M. D.
Sept 15 1920 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL DATE OF BURIAL
Rowland Cemetery Sept 16 1920

20. UNDERTAKER ADDRESS
A. Leonard Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2009
File No. 3181 0
Registered No. 121

1. PLACE OF DEATH
County of Ownhee
City of Cliffs Idaho
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rosella Lessman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married

6. DATE OF BIRTH: Sept 12 (Month) (Day) 1884 (Year)

7. AGE: 36 Yrs. 0 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Wm Smith Colora

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Susanna E Scarlet

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph Lessman
(Address) Cliffs Idaho

15. Filed Sept. 27 1920 John A. Meyers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 23 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept-18 - 1920, to Sept 23 - 1920, that I last saw h.. alive on Sept-23 1920, and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Heart failure

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Chronic Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S B Dudley M. D.

9-27 1920 (Address) Caldwell, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 9-27 1920

20. UNDERTAKER: C. W. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31811
Registered No. 35

1. PLACE OF DEATH

County of Payette County
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
White	White	Married

6. DATE OF BIRTH: May (Month) 31 (Day) 1864 (Year)

7. AGE: 51 Yrs. 7 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clay Co, Mo.

10. NAME OF FATHER: J. J. Baker

11. BIRTHPLACE OF FATHER (State or Country): Henery Co, Ky.

12. MAIDEN NAME OF MOTHER: Lucy J. Mitchel

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E. Jackson.
(Address) 1018 Boise K. & Ino.

15. Filed Sept 30 1920 J. C. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to Sept 25 1920, that I last saw him alive on Sept 25 1920, and that death occurred on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:
Cancer of face

(Duration) Several Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. N. Avery M. D.
9/30/1920 (Address) Payette Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	Oct 1 1920
20. UNDERTAKER: Glenn & Landon	ADDRESS: Payette Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

31812

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 25

Primary Registration District No. 2072

File No. 9

Registered No. 105

1. PLACE OF DEATH.

County of Power

City of Am Falls

(No. Cor. Jail St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Robert Caven (Supposed to be)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Not known

6. DATE OF BIRTH. Not Known (Month) (Day) (Year)

7. AGE: Not known (about 45) Yrs. Mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: not known

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): not known

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant)

(Address)

15. Filed 1920 R. F. Mock Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 28 (Day) 20 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191..., and that death occured on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Hanged (Suicide)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration 0 yrs. mos. ds.

(Signed) A. W. Adams Coroner

19... (Address) American Falls, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: American Falls

DATE OF BURIAL: 10-3 1920

20. UNDERTAKER: A. W. Adams

ADDRESS: Am Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31813

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3

Registered No. 104

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Power

City of Amer Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 29

Primary Registration District No. 2972

(No. Bethany Hospital St.)

2. FULL NAME Wm P Phillips

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~(Write the word.)~~ Single

6. DATE OF BIRTH. Dec 29 1910
(Month) (Day) (Year)

7. AGE 10 Yrs. 9 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) American Dakota

10. NAME OF FATHER W. A. Phillips

11. BIRTHPLACE OF FATHER (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Susie Taylor

13. BIRTHPLACE OF MOTHER (State or Country) New York Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Susie Phillips
(Address) Amer. Falls Ida RFD.

15. Filed 10-9 1920 R. F. Nott Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1920 to Sept 28 1920, that I last saw him alive on Sept 28 1920 and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary) Appendicitis

(Duration 1 yrs. 1 mos. ds.

(Signed) O. F. Belyea M. D.

9/29 1920 (Address) Amer. Falls. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Aberdeen, Ida — DATE OF BURIAL Sept 30 1920

20. UNDERTAKER C. W. Davis — ADDRESS Amer. Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

31814

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 20
Primary Registration District No. 2702
File No. 3
Registered No. 106

1. PLACE OF DEATH.
County of Power
City of Rockland
(No. 1 Mile N. E. of town St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matthew Phelps Fifield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. June (Month) 18 (Day) 1830 (Year)

7. AGE: 90 Yrs. 3 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Levi Fifield

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Amy Tracy

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm. Phelps Fifield
(Address) Rockland Idaho

15. Filed 10-9 1920 R. T. Nott Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~Oct~~ Sept (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Senile decay,

(Duration) 6 Yrs. — mos. — ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) V. G. Logan M. D.
Oct 1 1920 (Address) Rockland Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 12 yrs. — mos. — days. In the State 13 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Weston Idaho

19. PLACE OF BURIAL OR REMOVAL: Weston Idaho — DATE OF BURIAL: Oct 3 1920

20. UNDERTAKER: A. W. Davis — ADDRESS: Am Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 31816
Registered No. 27

1. PLACE OF DEATH
County of Teton
City of Tetonia
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Justin Jerry Merrill
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: May (Month) 24 (Day) 1844 (Year)

7. AGE: 76 Yrs. 4 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Harnessmaker
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Justin Merrill

11. BIRTHPLACE OF FATHER (State or Country): Dont know

12. MAIDEN NAME OF MOTHER: Cameelia Merrick

13. BIRTHPLACE OF MOTHER (State or Country): Dont know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. Arthur Dale.
(Address): Cache, Idaho.

15. Filed Oct 7 1920 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, ~~That I attended deceased from~~ ..... 19..... to ..... 19..... that I last saw h..... alive on ..... 19..... and that death occurred on the date stated above, at 9:30 A.M.

The CAUSE OF DEATH* was as follows:
Old Age.
No. Physician.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
9-28 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cache Cemetery | DATE OF BURIAL: Sept 29 1920

20. UNDERTAKER: E J King. | ADDRESS: Driggs, Ida.

FORM V. S. No. 5-A—25 M. 1-19.

31817

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
(No. ..... , ... St.)
File No. .....
Registered No. 26

1. **PLACE OF DEATH**
County of Teton
City of Tetonia
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** John Latham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male
4. **COLOR OR RACE**: White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): married

6. **DATE OF BIRTH**: June (Month) – 9 (Day) – 1833 (Year)

7. **AGE**: 87 Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. **BIRTHPLACE** (State or Country): Vermont

10. **NAME OF FATHER**: John Latham

11. **BIRTHPLACE OF FATHER** (State or Country): Vermont

12. **MAIDEN NAME OF MOTHER**: Hubbard.

13. **BIRTHPLACE OF MOTHER** (State or Country): Vermont

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) D. D. Latham
(Address) Tetonia, Ida.

15.
Filed Oct 7th 1920
Martha Marker
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Sept. (Month) 20th (Day) 1920 (Year)

17. I ~~HEREBY CERTIFY~~, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
No Physician
Old age.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. S. Hoops M. D.
19..... (Address) P.O. Tetonia Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Tetonia Cemetery — **DATE OF BURIAL**: Sept. 23 1920

20. **UNDERTAKER**: L. O. Thing — **ADDRESS**: Driggs, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 31821
Registered No.

1. PLACE OF DEATH.
County of Twin Falls.
City of Buhl
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Walters.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. March (Month) 5 (Day) 1836 (Year)

7. AGE: 84 Yrs. 5 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... none
(b) General nature of industry, business, or establishment in which employed (or employer)..... none

9. BIRTHPLACE (State or Country) Orreille Ohio.

10. NAME OF FATHER John Brown

11. BIRTHPLACE OF FATHER (State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Sarah Burleson

13. BIRTHPLACE OF MOTHER (State or Country) Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F A Irmen. (information by Cyrus Walters, son)
(Address) .....

15. Filed 9-4 1920 J. H. Hurley Local Registrar

BYNS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 1920, to Sept 2 1920, that I last saw her alive on Aug 27 1920, and that death occured on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows:
Old age.

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bronchitis, arteriosclerosis
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F A Irmen M. D.
9/11 1920 (Address) Buhl Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Siler — DATE OF BURIAL: Sept 5 1920

20. UNDERTAKER: Homer B Evans — ADDRESS: Buhl.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31822
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
Registration District No. 39
Primary Registration District No. 2087
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tracy Dixson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: /
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Burke Idaho.

10. NAME OF FATHER: Owen Dixson

11. BIRTHPLACE OF FATHER (State or Country): Nebraska.

12. MAIDEN NAME OF MOTHER: Lacca Millington

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Owen Dixson
(Address) .....

15. Filed 9-3 1920 J. N. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 30 1920, to Sept 2 1920
that I last saw h[im] alive on Sept 2 1920
and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia Both
Con Complicated with
Pyaemia Abscess w/heart
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Hartzell M. D.
9/3 1920 (Address) Burke Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burke
DATE OF BURIAL: Sept 3 1920

20. UNDERTAKER: Homer B. Evans
ADDRESS: Burke Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 31823
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Derrick B. Hartwell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. ~~SINGLE, MARRIED, WIDOWED OR DIVORCED~~ (Write the word.): Married

6. DATE OF BIRTH: Oct 11 1845 (Month) (Day) (Year)

7. AGE: 74 Yrs. 10 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Hampshire.

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): Not known

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Maud Hartwell
(Address) Burley Idaho

15. Filed 9-5 1920 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 4 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1920, to Sept 4 1920, that I last saw h. alive on Sept 4 1920 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

2

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Paralysis Agitans

(Duration) 15 yrs. ..... mos. ..... ds.

(Signed) A. Ira Clark M. D.

Sept 5 1920 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Cemetery — DATE OF BURIAL: Sept 7 1920

20. UNDERTAKER: Neville & Sligo — ADDRESS: Burley Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2084
File No. 31824
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. Washington Griffen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 27 (Day) 1840 (Year)

7. AGE: 80 Yrs. 5 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. W. Pellman
(Address)

15. Filed 9-17 1920
J. A. Merrifield
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1920, to Sept. 10 1920, that I last saw h[illegible] alive on Sept. 9 1920, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
Brights Disease
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. A. Marsh, M. D.
Sept 13 1920 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery | DATE OF BURIAL: 9/13 1920

20. UNDERTAKER: Howell & Legg | ADDRESS: Buhl Ida

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31825
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Burke (No. , St.)

Registration District No. 39
Primary Registration District No. 2087

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred King

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Aug. (Month) 26 (Day) 1918 (Year)

7. AGE: 2 yrs. 1 mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Castleford Ida.

10. NAME OF FATHER: D. N. King

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Clara Whaley

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D N King
(Address) Castleford Ida

15.
Filed 9-25 1920 J. H. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-22 1920, to 9-24 1920
that I last saw him alive on 9-24 1920
and that death occurred on the date stated above, at 1 a. M.
The CAUSE OF DEATH* was as follows:
Diarrhea

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. H. Murphy M. D.
9-25 1920 (Address) J. H. Murphy

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds.
In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burke
DATE OF BURIAL: Sept 26th 1920

20. UNDERTAKER: Homer B. Evans
ADDRESS: Burke

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

Duncan

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Twin Falls
City of Burke

Registration District No. 39
Primary Registration District No. 2087
(No. ....., ... St.)

File No. 31827
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Jackson Armstrong

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 3 (Day) 1845 (Year)

7. AGE: 75 yrs. 3 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) Retired

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Thos Armstrong

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Melina Lackrig

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Roberts
(Address) Burke Ida

15.
Filed 9-29 1920 J. W. Wrigley
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1, 1920, to Sept 28, 1920.
that I last saw h just alive on 9-26 1920.
and that death occurred on the date stated above, at 5:00 P M.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

..... (Duration) ..... yrs. ..... mos. 5 ds.
Contributory (Secondary) Chronic Nephritis and Myocarditis
..... (Duration) 1 yrs. 24 mos. ..... ds.

(Signed) George D. Landell M. D.
9-30 1920 (Address) Burke Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burke Cemetery — DATE OF BURIAL: Sept 29 1920

20. UNDERTAKER: Homer B Evans — ADDRESS: Burke

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 21828
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of [illegible] (No. [illegible] St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Elwood Grieve
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (~~Married~~) (~~Widowed~~) (~~Divorced~~) (~~word.~~)

6. DATE OF BIRTH: Oct (Month) 8 (Day) 1920. (Year)

7. AGE: Yrs. Mos. 18 Hours
IF LESS than 1 day how many 18 hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ~~[illegible]~~
(b) General nature of industry, business or establishment in which employed (or employer): ~~[illegible]~~

9. BIRTHPLACE (State or Country): Twin Falls.

10. NAME OF FATHER: W. A. Grieve

11. BIRTHPLACE OF FATHER (State or Country): N. Dak.

12. MAIDEN NAME OF MOTHER: Ella Collins

13. BIRTHPLACE OF MOTHER (State or Country): Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. A. Grieve
(Address) Filer Ida.

15. Filed Oct 12 1920. John Y. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 8 — 1920, to Oct. 9 — 1920, that I last saw him alive on Oct. 9 — 1920, and that death occurred on the date stated above, at 11 A. M.
The CAUSE OF DEATH* was as follows:

Intussusception.
(Duration) Yrs. mos. ds.
Contributory (Secondary) Maternal Septicaemia.
(Duration) yrs. mos. 2 ds.
(Signed) H. A. Dwight M. D.
Oct 9 1920 (Address) Filer, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 10-10 1920

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31829
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Ester Shelley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~(Write one word.)~~ Single

6. DATE OF BIRTH: Oct (Month) 11 (Day) 920 (Year)

7. AGE: — Yrs. — Mos. 1 ds.
IF LESS than 1 day how many 10 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls

10. NAME OF FATHER: E.J. Shelley

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lizzy Cleavenger

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Shelley
(Address) E. J. "

15. Filed Oct 12 1920 John F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-11 1920, to 10-11 1920, that I last saw h.er alive on 10-11 1920, and that death occurred on the date stated above, at 10A M.

The CAUSE OF DEATH* was as follows:
Patent Foramen Ovale

(Duration) Yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) John F. Coughlin M. D.
10-1 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 10-12 1920

20. UNDERTAKER: P.J. Grossman
ADDRESS: Twin Falls

Id.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31830

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. ..... St. ..... Registered No. .....)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sophia C. Sutcliffe
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1849 (Year)

7. AGE: 71 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Sutcliffe
(Address) Hansen Ave

15. Filed Oct 12 1920 John F Coughlan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1920 to October 7, 1920 that I last saw h.. alive on October 7 1920 and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Liver
Arterio Sclerosis
Chronic Nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Joseph Regal, M. D.
Oct 12, 1920 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Appleton City Mo
DATE OF BURIAL: 10-. 1920
20. UNDERTAKER: P.J. Grossman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

Primary Registration District No. 1685

File No. 31831

City of (— (No. ——, ——St.)

Registered No. ——

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca Heigwood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Mar 16 (Month) (Day) 1836 (Year)

7. AGE: 84 Yrs. 10 Mos. 12 da.

IF LESS than 1 day how many ——— hrs. or ——— min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: retired

(b) General nature of industry, business or establishment in which employed (or employer): ———

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: Henry Heigwood

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: ———

13. BIRTHPLACE OF MOTHER (State or Country): ———

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Martha C. Johnson

(Address) ———

15. Filed Sept 29 1920 — John F Caughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep 28 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1919 to Sept 28 1920 that I last saw her alive on Sept 27 1920 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Arteria-sclerosis

(Duration) Several Yrs. ——— mos. ——— ds.

Contributory (Secondary) ———

(Duration) ——— yrs. ——— mos. ——— ds.

(Signed) Chas. R. Scott M. D.

9/25 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ——yrs. ——mos. ——days. In the State ——yrs. ——mos. ——days

Where was disease contracted if not at place of death? ———

Former or usual residence ———

19. PLACE OF BURIAL OR REMOVAL: Done Oregon — DATE OF BURIAL ——— 19——

20. UNDERTAKER: L E Merrill — ADDRESS Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ....., ... St.)

File No. 31832
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas Bevercombe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan 16 (Month) (Day) 1836 (Year)

7. AGE: 84 Yrs. 8 Mos. 5 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) x W. A. Bevercombe
(Address) Twin Falls Ida.
612 Blue Lake

15. Filed Sept 29 1920
John L. Anglin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1920 to Sept 21 1920
that I last saw him alive on Sept 21 1920
and that death occurred on the date stated above, at 6 P M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. C. Lambert M. D.
Sept 21 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Creston Iowa	1920
20. UNDERTAKER P. G. Grossman	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1084
File No. 31833
Registered No.

1. PLACE OF DEATH

County of
City of
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Alfred Rector

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: June (Month) Fourth (Day) 1884 (Year)

7. AGE: 36 Yrs. 3 Mos. 15 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Garage Owner and
(b) General nature of industry, business or establishment in which employed (or employer): Auto mechanic

9. BIRTHPLACE (State or Country): Echo Oregon

10. NAME OF FATHER: William Rector

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Julia Kinney

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jennie Rector
(Address) Oakley Idaho

15. Filed Sept 29 1920 John F Griffin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September (Month) Nineteenth (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidental Drowning

.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary)
.....(Duration) .....yrs.....mos.....ds.

(Signed) P. J. Grossman Coroner
Sept 22 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Walla Walla Wash. | DATE OF BURIAL: 19.....

20. UNDERTAKER: P. J. Grossman | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls — Registration District No. 37
Primary Registration District No. 1085
City of " " (No. ..... St.)
File No. 31834
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas. E. Carpenter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
Male	White	Single

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE 38 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer): Contractor

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. J. Grossman
(Address) Twin Falls Idg.

15. Filed Oct 9 1920 — John L. Coughlan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Fracture of Skull

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. J. Grossman Prosser M. D.
10-8 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cambridge Ohio	..... 19.....
20. UNDERTAKER J. J. Grossman	ADDRESS Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 10x6
(No. ..... , ... St.)

File No. 31835
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Bolz.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.): Married

6. DATE OF BIRTH: April (Month) 6 (Day) 1859 (Year)

7. AGE: 61 Yrs. 5 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Leo Bolz.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dorthow

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Howard Bolz
(Address) Twin Falls

15. Filed Oct 12 1920 John Y Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1920, to Sept 27 1920, that I last saw him alive on Sept 26 1920, and that death occurred on the date stated above, at 12:20 M.
The CAUSE OF DEATH* was as follows: Cerebral hemorrhage

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. O. Sias M. D.
Sept 27 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 9/30/1920

20. UNDERTAKER: J. F. Goodman — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31836
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur J Tryon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug 13 (Month) 13 (Day) 1870 (Year)

7. AGE: 50 Yrs. 1 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: Tryon

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Alice Upton

13. BIRTHPLACE OF MOTHER (State or Country): New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Arthur J. Tryon
(Address) Hagelton

15. Filed Sept 16 1920 John H Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 13, 1920, to Sept 13 1920
that I last saw h.... alive on Sept 13 1920
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Hemorrhage of Brain

(Duration) Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Jos Boyd M. D.
Sept 14 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho DATE OF BURIAL: 9-12 1920

20. UNDERTAKER: L E Veatch ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 87
Primary Registration District No. 1085
(No. ____, ____ St.)

File No. 31837
Registered No. ____
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward F. Meyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Don't Know. 1 (Month) (Day) (Year)

7. AGE: 35 Yrs. ____ Mos. ____ ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): -

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Chas Meyer

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Mrs. Edd Meyer
(Address) Twin Falls, Ida.

15. Filed Sept 16 1920 John F Coughlen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 7 8 1920, to Sept 7th 1920 that I last saw h. alive on Sept 7th 1920, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:
Typhoid fever

(Duration) ____ Yrs. ____ mos. 10 ds.
Contributory (Secondary): Myocarditis
(Duration) ____ yrs. ____ mos. 2 ds.

(Signed) John F Coughlen M. D.
9-10 1920 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 9/9 1920

20. UNDERTAKER: J. J. Grossman — ADDRESS: Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31838
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME S. A. Orr

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ~~Single~~ Married

6. DATE OF BIRTH: Nov. (Month) 22 (Day) 1850 (Year)

7. AGE: 69 Yrs. 9 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lawyer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Sample Orr

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Olivia Kanston

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X [illegible]
(Address) Twin Falls Idaho

15. Filed Sept 16 1920 John F Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 8th 1920, to Sept 10th 1920 that I last saw h. alive on Sept 10th 1920 and that death occurred on the date stated above, at 1:30 P. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease
(Duration) 5 Yrs. mos. ds.
Contributory (Secondary)
(Duration) 1 yrs. mos. ds.

(Signed) John F Coughlin M. D.
9-14 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Ida. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: P. J. Freeman ADDRESS Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31839

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)
Registered No. .....

2. FULL NAME Rollin Hugh Dinnick
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Widower

6. DATE OF BIRTH: June (Month) 7 (Day) 1850 (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brick Layer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Nelson Dinnick

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: — Luginbuel

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Dinnick
(Address) .....

15. Filed Sept 16 1920 John F Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 26 1920 to Sept 7 1920 that I last saw him alive on Sept 7 1920, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John R Morgan M. D.
Sept 7 1920 (Address) Twin Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: 9/10 1920

20. UNDERTAKER: E. J. Donnan
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31840
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, write NAME instead of street and number.

2. FULL NAME William H. J R Cawood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: Sep 17 (Month) (Day) 1920 (Year)

7. AGE: Yrs. Mos. 6 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Cawood

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Ina Groves

13. BIRTHPLACE OF MOTHER (State or Country): Kans

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Cawood
(Address) 253 4 ave East

15. Filed Sept 28 1920 — John F Coughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 17 1920, to Sept 23 1920
that I last saw h alive on 19
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Acute nephritis
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H W [illegible] M. D.
Sept 24 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: Sept 24 1920

20. UNDERTAKER: [illegible] — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31841
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louis allsberry
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June 20 (Month) (Day) 1920 (Year)

7. AGE: Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Vernon allsberry

11. BIRTHPLACE OF FATHER (State or Country): St Louis

12. MAIDEN NAME OF MOTHER: Daisy Smith

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W J Allsberry
(Address)

15. Filed Sept 25 1920 John T Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 24 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1920 to Sept 24 1920
that I last saw h[illegible] alive on Sept 24 1920
and that death occurred on the date stated above, at 12 A.M.
The CAUSE OF DEATH* was as follows:
Cholera infantum
(Duration) Yrs. mos. 1 ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) C. D. Weaver M. D.
19 (Address) Twin Falls.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho | DATE OF BURIAL: Sept 26 1920

20. UNDERTAKER: [illegible] | ADDRESS: Twin Falls

Dr Scott

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31842
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. Herman St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Nellan "Twin"
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 25 (Day) 920 (Year)

7. AGE: 0 Yrs. Mos. 19 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: James Nellan

11. BIRTHPLACE OF FATHER (State or Country): Ark.

12. MAIDEN NAME OF MOTHER: Elsie Fry

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Nellan
(Address) Twin Falls Ida

15. Filed Sept 28 1920 John F Coughlan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1920, to Sept 13 1920 that I last saw h~~im~~ alive on Sept 13 1920, and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Malnutrition - Born premature

(Duration) Yrs. mos. 19 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas. K. Scott M. D.
9/19 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: 9/20 1920

20. UNDERTAKER: D. G. Grossman — ADDRESS: Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31843
Registered No. 729

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helen Nellon "Twin"
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: Aug (Month) 25 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: James Nellon

11. BIRTHPLACE OF FATHER (State or Country): Ark.

12. MAIDEN NAME OF MOTHER: Elsie Frey

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Nellon
(Address) Twin Falls, Ida

15. Filed Sept 28 1920 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 25 1920, to Sept 19 1920 that I last saw her alive on Sept 19 1920 and that death occurred on the date stated above, at 7 a. M.
The CAUSE OF DEATH* was as follows:

Malnutrition - born premature

..... (Duration) ..... Yrs. ..... mos. 25 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Chas. R. Scott M. D.
9/19 1920 (Address) Twin Falls - Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: 9/20 1920

20. UNDERTAKER: R.G. Grossman — ADDRESS: Twin Falls Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31844
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella A Wheeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July 29 (Month) (Day) 1843 (Year)

7. AGE: 67 Yrs. 2 Mos. 21 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: E E Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Almira Wheeler / Ella Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Inez W Fuller
(Address): 735 3rd No Twin Falls

15. Filed Sept 25 1920 — John F Coughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 17th 1920, to Sept 20th 1920
that I last saw her alive on Sept 20 1920
and that death occurred on the date stated above, at 1 25 P.M.
The CAUSE OF DEATH* was as follows:

Ex Opthelmic Goiter acute

(Duration) Yrs. 2 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Emeren L Freeman M. D.
9/21 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone Idaho — DATE OF BURIAL 19

20. UNDERTAKER: J E Veatch — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 31845
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter D. Wineland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

6. DATE OF BIRTH: Don't Know (Month) (Day) 1 (Year)

7. AGE: about 80 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: " "

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. A. Snyder
(Address) Twin Falls Ida

15. Filed Sept 28 1920 John H. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1920 to Sept 22 1920 that I last saw h[illegible] alive on Sept 22 1920 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
(Senile) Pneumonia
Broncho
(Duration) 2 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) D. C. Grossman M. D.
19 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: 9-24 1920

20. UNDERTAKER: D. C. Grossman
ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1845
File No. 31846
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary C Harris

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 4 (Day) 1851 (Year)

7. AGE: 69 Yrs. 4 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: house wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: William Block

11. BIRTHPLACE OF FATHER (State or Country): Mat Missouri

12. MAIDEN NAME OF MOTHER: Mary Bacon

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cyrus B J Harris
(Address) Salem Idaho

15. Filed Oct 16 1920 John Haughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1920, to Oct 16th 1920 that I last saw h[illegible] alive on Oct 15th 1920, and that death occurred on the date stated above, at [illegible] P.M.

The CAUSE OF DEATH* was as follows:
Myocarditis & valvular heart disease.

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) John F Vaughan M. D.
10-16 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rest Burial Park Idaho DATE OF BURIAL 19

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31847

Registered No.

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

Primary Registration District No. 2085

City of Eden (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur G Shield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Single

6. DATE OF BIRTH: June 30 (Month) (Day) 1880 (Year)

7. AGE: 40 Yrs. 9 Mos. 13 ds. — IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James W Shield

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary Gilliland

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): James W Shield
(Address):

15. Filed Sept 16 1920 — John F Coughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11 1920 to Sept 14 1920, that I last saw h[illegible] alive on Sept 14 1920, and that death occurred on the date stated above, at 6h M.

The CAUSE OF DEATH* was as follows:
Fracture of base of skull result of accident.
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Hugo Gonduk M. D.
Sept 15 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idaho — DATE OF BURIAL: 9-15 1920

20. UNDERTAKER: L E Wecrth — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD of HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 31848
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Julian Helman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: January 13 1920 (Month) (Day) (Year)

7. AGE: Yrs. 8 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Kimberly

10. NAME OF FATHER: Chas W. Helman

11. BIRTHPLACE OF FATHER (State or Country): Kans.

12. MAIDEN NAME OF MOTHER: Lena Estell

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas W Helman
(Address)

15. Filed Sept 28 1920 John F Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 10 1920 to Sept. 14 1920 that I last saw h~~im~~ alive on Sept 10 1920 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Cerebro Spinal Meningitis

(Duration) Yrs. 8 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) D. E. McGinnis M. D.
19 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL 19

20. UNDERTAKER: J. F. Grossman
ADDRESS Twin Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Valley
City of ..... (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 15
Primary Registration District No. .....

File No. 31849
Registered No. 66
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Jacob Finkinen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: not known (Month) 1 (Day) (Year)

7. AGE: 47 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Finland

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. E. Knoffle
(Address) Cascade Idaho

15.
Filed 9-23 1920 M. McDonald
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
9 (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1920, to ..... 191....
that I last saw h..... alive on ..... 191....,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Tuberculosis

..... (Duration) 5 yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. E. Knoffle M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs..... mos..... ds. In the State..... yrs..... mos..... ds.
Where was Disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Finn Cemetery
DATE OF BURIAL: 9-17 1920

20. UNDERTAKER: None
ADDRESS: None

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 87

Primary Registration District No. ____

(No. ____, ____ St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31850

Registered No. ____

1. PLACE OF DEATH.

County of Washington

City of Midvale

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Glenn Blain

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 3 (Day) 1 (Year)

7. AGE: 63 Yrs. 11 Mos. 8 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Joe Blain

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jessie Blain

(Address) Meridale

15. Filed Oct 6 1920 Fackrell Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1920, to Oct 6 1920, that I last saw him alive on Oct 6 1920, and that death occured on the date stated above, at 12 00 M.

The CAUSE OF DEATH* was as follows:

Intestinal paralysis & toxemia

(Duration) ____ Yrs. ____ mos. ____ ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) W. T. Sudweeks M. D.

Oct 6 1920 (Address) Midvale, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Meridale — DATE OF BURIAL: Oct 7 1920

20. UNDERTAKER: C. R. Fackrell — ADDRESS: Meridale

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 87
Primary Registration District No.
File No. 31851
Registered No.

1. PLACE OF DEATH.
County of Washington
City of Mavale
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Clayton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 29 (Day) 1920 (Year)

7. AGE: 1 hour Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country) Midvale Ida

10. NAME OF FATHER Claud Clayton

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER Hazel Greenwell

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Claud Clayton
(Address) Midvale Ida

15. Filed 9-26-1920. F A Schmidt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1920, to Sept 26 1920, that I last saw h alive on Sept 26 1920, and that death occured on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Still Born
Premature

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) Dr F A Schmidt M. D.
9-26-1920 (Address) Midvale

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Midvale — DATE OF BURIAL: Oct 2 1920

20. UNDERTAKER: C R B Jackman — ADDRESS: Midvale Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 24654

A stillbirth must be registered both as a birth and death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner*, (*b*) *Cotton mill;* (*a*) *Salesman*, (b) *Grocery;* (*a*) *Foreman*, (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers*, who receive a definite salary), may be entered as *Housewife, Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated this: *Farmer* (*retired, 6 yrs.*) For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH.—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcinoma, Sarcoma*, etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL, *septicemia*," "PUERPERAL *peritonitis*," etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train —accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory."

9 # 2

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31852
Registered No. .....

1. PLACE OF DEATH.
County of Washington
City of Midvale
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 87
Primary Registration District No. .....

2. FULL NAME C H Tupper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH.
March (Month) 29 (Day) 1854 (Year)

7. AGE
66 Yrs. 5 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Veterinary
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Cherryfield Maine, Washington

10. NAME OF FATHER David Tupper

11. BIRTHPLACE OF FATHER (State or Country) Cherryfield Maine, Washington

12. MAIDEN NAME OF MOTHER Rebecca Lawerance

13. BIRTHPLACE OF MOTHER (State or Country) Maine,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Edith Tupper
(Address) Midvale, Ida.

15.
Filed 10-4-1920
F A Schmitt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sept. (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 11 1918, to Sept. 11 1920, that I last saw h[illegible] alive on Sept 11 1920 and that death occured on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Diabetis, Mellitis

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F A Schmitt M. D.
9-11 1920 (Address) Midvale Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Midvale
DATE OF BURIAL: Sept 12 1920

20. UNDERTAKER: C R Pashmuta
ADDRESS: Midvale

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-A—25 M. 1-19.

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CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.....
Primary Registration District No.....
(No.....St.)

File No. 31853
Registered No.....

1. PLACE OF DEATH

County of Washington
City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Alvin English

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June 8 1918
(Month) (Day) (Year)

7. AGE: Yrs. 2 Mos. 3 ds. 15
IF LESS than 1 day how many.....hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: No
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Yankton Dak. Ter.

10. NAME OF FATHER: James B. English

11. BIRTHPLACE OF FATHER (State or Country): Asherton Ont. Can.

12. MAIDEN NAME OF MOTHER: Rosa Ann Hazel

13. BIRTHPLACE OF MOTHER (State or Country): Mt Vernon Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry E. Horn
(Address) Kilgore Idaho

15. Filed 10-7-20 19.....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 1920, to Sept 24 1920, that I last saw him alive on Sept 23 1920, and that death occurred on the date stated above, at 3 a M.
The CAUSE OF DEATH* was as follows:

Whooping cough

(Duration) Yrs. 1 mos. ds.
Contributory (Secondary) Bronchitis & enlarged tonsils
(Duration) yrs. mos. 15 ds.

(Signed) F. W. Kennedy M. D.
9-28 1920 (Address) Meadows Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Adams Creek — DATE OF BURIAL 19.....

20. UNDERTAKER: J A Hedelen — ADDRESS Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31854

Registered No.....

Registration District No.....

Primary Registration District No.....

(No....., ...St.)

1. PLACE OF DEATH

County of Washington

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernard Lee Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH

July (Month) 12 (Day) 1918 (Year)

7. AGE

2 Yrs. 2 Mos. 18 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER Wm Young

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Virginia Quigley

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant).....

(Address).....

15. Filed 10-7-20 19..... Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Sept (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1920, to Sept 30 1920, that I last saw h.im alive on Sept 30 1920, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Poison, probably from Denatured

.....(Duration) .....Yrs.....mos.....ds.

Contributory (Secondary).....

.....(Duration) .....yrs.....mos.....ds.

(Signed) E A Wiseman M. D.

10/1 1920 (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Indian Valley	Oct 2 1920
20. UNDERTAKER	**ADDRESS**
J A Anderson	Cambridge Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31855
Registered No.

1. PLACE OF DEATH
County of Washington
City of Cambridge
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ewald Wilkerson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 29 (Day) 1920 (Year)

7. AGE: 2 Yrs. 6 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Na
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington Co Ida

10. NAME OF FATHER: Maurice Wilkerson

11. BIRTHPLACE OF FATHER (State or Country): Washington Co Ida

12. MAIDEN NAME OF MOTHER: Blanch Shroyer

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M Wilkerson
(Address) Cambridge Ida

15. Filed 10-7-20, 19 — W W Whitman, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 29 1920, to Sept 8 1920, that I last saw h.im. alive on Sept 8 1920 and that death occurred on the date stated above, at 7.30 A.M.

The CAUSE OF DEATH* was as follows:
Cholera Infantum

(Duration) Yrs. mos. 15 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C A Williamson M. D.
9/8 1920 (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Adelma — DATE OF BURIAL: Sept 9 1920

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31830

Registered No.

1. PLACE OF DEATH

County of Washington

City of Cambridge

(No. ....., ... St.)

Registration District No. .....

Primary Registration District No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriett M Tuttle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 10 (Day) 1 (Year)

7. AGE: 54 Yrs. 10 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): South Hemton, Province of Novascotia

10. NAME OF FATHER: W F Hanson

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: Hartt Rubley

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C W. Tuttle

(Address) .....

15. Filed 10-7-20 19..... O W Coleman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920, to Sept 27 1920, that I last saw her alive on Sept 27 1920 and that death occurred on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. 2 mos. 24 ds.

(Signed) O W Coleman M.D.

19..... (Address) Cambridge Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Cambridge Idaho DATE OF BURIAL: Sept 28 1920

20. UNDERTAKER: Jas. A. Sudelson ADDRESS: Cambridge Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31857
Registered No.

1. PLACE OF DEATH
County of Ada
City of
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9
Primary Registration District No.
(No. 4 Miles N. E. of Star.)

2. FULL NAME Isaac A. Moore

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: (Month) (Day) 1833 (Year)

7. AGE: 87 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Minister
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. B. Tucker
(Address) 1501 N 11th Boise Ida.

15. Filed Oct 15 1920 Frederick L Lewis
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Oct 14 1920 ~~to~~ ~~19~~, that I ~~last saw her alive on~~ ~~19~~, and that death occurred on the date stated above, at 6. A. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart trouble

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Clyde E Summers, Coroner M. D.
10/13 1920 (Address) Boise Ida Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Star Cemetery, DATE OF BURIAL: Oct 16 1920

20. UNDERTAKER: Summers & Tarbet ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 9.

Primary Registration District No. .....

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31858

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Ada.

City of Ward 9 of Eagle

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lloyd C. Hollingsworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. June (Month) 22 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 2 ds. 22

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... None.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Claud E. Hollingsworth

11. BIRTHPLACE OF FATHER (State or Country) Iowa.

12. MAIDEN NAME OF MOTHER Mary Van Voorhis

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Claud E. Hollingsworth

(Address) Eagle - Idaho

15.

Filed Sept 13 1920 Frederic K. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 12 1920, to Sept 13 1920, that I last saw him alive on Sept 13 1920, and that death occured on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) ..... Yrs. ..... mos. a few days ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Frederic K. Lewis M. D.

Sept 13 1920 (Address) Eagle, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Morris Hill Cemetery Boise - Idaho

DATE OF BURIAL: Sept 14 1920

20. UNDERTAKER: Buried by family

ADDRESS: Boise-RR 2-

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

EVANS - YORK CO., PTRS. & BDRS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31859

Registered No. 85

1. PLACE OF DEATH

County of Ada

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration, District No. 2004

(No. Division Ave. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Uriel Fjelstrom Jr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May 15 (Month) (Day) 1920 (Year)

7. AGE: — Yrs. 4 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Charles U. Fjelstrom.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Ruth E. Snyder.

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. A. Fjelstrom

(Address) Payette, Idaho.

15. Filed Oct 5 1920 R H Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 5 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from —— 19— to —— 19—

that I last saw him ~~alive~~ died on Oct 5 1920,

and that death occurred on the date stated above, at 6 A M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease.

No physician in attendance at death.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Premature birth.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry Krebs, Deputy Coroner M.D.

10/5 1920 (Address) Boise. Ada Co. Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Summers & Krebs. ADDRESS Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2017
(No. Soldiers Home Hospital)

File No. 31860
Registered No. 8

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George W. Epley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Widower (Write word.)

6. DATE OF BIRTH
Oct 9 (Month) (Day) 1843 (Year)

7. AGE
76 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Civil War Veteran
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country) —

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Burl Reamer
(Address)

15. Filed Oct 8 1920 P. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 8 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920 to Oct 8 1920
that I last saw h[im] alive on Oct 1st 1920
and that death occurred on the date stated above, at 3 A.M.
The CAUSE OF DEATH* was as follows:
Cardiac asthma

(Duration) 5 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Roscoe B Ward M. D.
10-8 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Geneva Nebraska	19
20. UNDERTAKER: Summers & Webb.	ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of —

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. 2017

(No. 3 Miles W of Boise St.)

File No. 31861

Registered No. 87

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jim Ng Gee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1838 (Year)

7. AGE: 82 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E. Summers

(Address) Boise Ida

15. Filed Oct 14 1920 — R. H. Pace, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1917 to Oct 14 1920 that I last saw him alive on Oct 14 1920, and that death occurred on the date stated above, at 8.30 P.M.

The CAUSE OF DEATH* was as follows:

Senility and Atrophic Gastritis

(Duration) 1 Yrs. mos. 7 ds.

Contributory (Secondary) Malnutrition

(Duration) yrs. 3 mos. 7 ds.

(Signed) F. N. Bratton M. D.

Oct 16 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pioneer Cemetery — DATE OF BURIAL: Oct 16 1920

20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 2004

File No. 31862

Registered No. 38

1. **PLACE OF DEATH**

County of Ada.

City of Boise,

(No.) 1/4 Mc South. Morris Hill Cemetery (St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Elizabeth Hannah.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Single

6. **DATE OF BIRTH** August 18, 1840.
(Month) (Day) (Year)

7. **AGE** 80 Yrs. 2 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Housework,

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Indiana

10. **NAME OF FATHER** Wm Nelson Hannah

11. **BIRTHPLACE OF FATHER** (State or Country) Indiana

12. **MAIDEN NAME OF MOTHER** Meribah Barricklow

13. **BIRTHPLACE OF MOTHER** (State or Country) Indiana

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) W. McC. Bratney

(Address) Boise Idaho.

15. Filed Oct 29 1920

R. H. Spade
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Oct, 28, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9th 1920, to Oct 28 1920, that I last saw her alive on Oct 28 1920, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Inanition from Starvation - Carcinoma of left lateral lobe of Thyroid gland - duration about (Duration) 5 mos. ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Cannon M. D.

10/28 1920. (Address) Boise Idaho.

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Morris Hill Cemetery — **DATE OF BURIAL** 10/30 1920

20. **UNDERTAKER** W. McC. Bratney — **ADDRESS** Boise Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31863
Registered No. 332

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 410 State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Josephine Coyne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	White	Single (Write the word.)

6. DATE OF BIRTH: Oct 3rd 1920 (Month) (Day) (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many 1 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Boise, Idaho.

10. NAME OF FATHER C. F. Coyne

11. BIRTHPLACE OF FATHER (State or Country) So Dak

12. MAIDEN NAME OF MOTHER Dorothy M Young

13. BIRTHPLACE OF MOTHER (State or Country) So. Dak.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C F Coyne
(Address) 1014 E. Fairmont St. Boise, Ida.

15. Filed Oct 4 1920 R. N. Bratt Local Registrar
D. Hoggs

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 3rd 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1920 to Oct 3 1920, that I last saw h.... alive on Oct 3 1920, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Pneumonia Flu Chronic Myocarditis
Pneumonia Oralis

(Duration) ....Yrs....mos. 1 hour ds.

Contributory (Secondary) —

(Duration) ....yrs....mos....ds.

(Signed) D P Hoggs M. D.

10-4 1920 (Address) 416 N. Walnut

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State ....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	10/4 1920

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31864
Registered No. 2330

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 621 Grove St.)
Registration District No.
Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Coze J. Dagres

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 13 1920 (Month) (Day) (Year)

7. AGE: 6 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise

10. NAME OF FATHER: J. H. Dagres

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Anna Karas

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Dagres
(Address) Boise Ida

15. Filed Oct 2 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 1 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1920 to Oct 1 1920 that I last saw her alive on Sept 1 1920 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Convulsions caused from pneumonia —
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Boyle M. D.
Oct 1 1920 (Address) Same Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/1 1920

20. UNDERTAKER: Gilmore & Feilen Funeral — ADDRESS: Boise

In Book

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

V

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31865

Registered No. 334

1. PLACE OF DEATH

County of Ada

City of Boise.

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 1027

(No. St. Alphonsus Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fredrick N. Furneaux

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Married (or widow)

6. DATE OF BIRTH: July (Month) 14 (Day) 1851 (Year)

7. AGE: 69 Yrs. 2 Mos. 20 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: — Furneaux

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mona Burneaux

(Address) Boise, Ida. R No. 1.

15. Filed Oct 5 1920

P. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19— to ——— 19—

that I last saw him ~~alive~~ dead on Oct 3 1920,

and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Fracture of skull.
Struck by automobile

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Harry Webb. Deputy Coroner.

10/5 1920 (Address) Boise Idaho Ada Co.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL ... 19...

20. UNDERTAKER: Summers & Webb — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

Pittenger

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31866
Registered No. 333

1. PLACE OF DEATH
County of Ada
City of Boise.
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004
(No. 1202 Washington St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Ray McBirney.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: Jan 8 (Month) (Day) 1917. (Year)

7. AGE: 3 Yrs. 8 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Harry R. McBirney.

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Ray Leonard

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry R. McBirney
(Address) Boise Idaho

15. Filed Oct 5 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 5 1920 to 10/5/20 1920, that I last saw h.er alive on 10/5/20 1920, and that death occurred on the date stated above, at 5:30 M.

The CAUSE OF DEATH* was as follows:

Chronic Kidney

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Fred. G. Vickery M. D.

10/5 1920 (Address) Overland

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Oct 6 1920

20. UNDERTAKER: Summers & Kebs. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
File No. 31867
Registered No. 338

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 1201 N. 12th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey Newland Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept 23rd 1920 (Month) (Day) (Year)

7. AGE: — Yrs. — Mos. 14 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise. Idaho.

10. NAME OF FATHER: Harvey W. Smith

11. BIRTHPLACE OF FATHER (State or Country): Ills.

12. MAIDEN NAME OF MOTHER: Florence Jolley

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey N Smith
(Address)

15. Filed Oct 7 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 6th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23rd 1920, to Oct 6th 1920, that I last saw him alive on Oct 6th 1920, and that death occurred on the date stated above, at 6. P. M.

The CAUSE OF DEATH* was as follows:

Some condition from birth not understood

(Duration) Yrs. mos. ds.

Contributory (Secondary) strangulation from falling of throat with mucus.

(Duration) yrs. mos. ds.

(Signed) J. W. Taylor M. D.

Oct 7th 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence: Boise. Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/7 1920

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise. Ida

Dr. Taylor.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

Frazier

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
File No. 31868
Registered No. 340

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1707 N. 13. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert James Chester

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April 7 1869 (Month) (Day) (Year)

7. AGE: 51 Yrs. 5 Mos. 29 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teamster
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Joseph Chester

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Helen Ryther

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. A. J. Chester
(Address) 1707 N 13th St. Boise

15. Filed Oct 8 1920 P. H. Arata Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1920 to Oct 6 1920 that I last saw h~~im~~ alive on Oct 6 1920, and that death occurred on the date stated above, at 3 P M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. L. Frazier M. D.
Oct 7 1920 (Address) 515 over Bard Bldg Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery, DATE OF BURIAL: Oct 8 1920

20. UNDERTAKER: Summers & Krebs ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Braxton,

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31869

Registered No. 342

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 110 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William James Wood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 21 (Month) 21 (Day) 1920 (Year)

7. AGE: Yrs. 4 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: J. L. Wood.

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Viva Seeley

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. L. Wood

(Address) 1421 Jefferson Boise Idaho

15. Filed Oct 13 1920 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1920 to Oct ~~24~~ 12 1920 that I last saw h.~~im~~ alive on Oct ~~24~~ 12 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Enteric Colitis.

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Meningitis

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) T. N. Braxton M. D.

Oct 13 1920 (Address) 509 Empire B. Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Idaho — DATE OF BURIAL: Oct. 14 1920

20. UNDERTAKER: Summers & Kreb — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31870

Registered No. 343

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 410, State St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ole Hanson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. ~~SINGLE~~, MARRIED, ~~WIDOWED OR DIVORCED~~ (Write the word.): Married

6. DATE OF BIRTH: May 3rd (Month) (Day) 1870 (Year)

7. AGE: 70 Yrs. 5 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Dont Know.

13. BIRTHPLACE OF MOTHER (State or Country): Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Seymour L. Hanson

(Address) Horse Shoe Bend

15. Filed Oct 14 1920

R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13" (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12th 1920, to Oct 13th 1920, that I last saw h.. alive on Oct 13 1920, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Embolism & thrombosis of mesenteric vessels, small intestine

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. O. McCalla M. D.

10/14 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Horse Shoe Bend, Idaho

19. PLACE OF BURIAL OR REMOVAL: Horse Shoe Bend Cemetery | DATE OF BURIAL: 10/15 1920

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise, Idaho

Dr. McCalla.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

1 [illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31871

Registered No. 344

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 110 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ellis Doris Hemphill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: March 7 1874 (Month) (Day) (Year)

7. AGE: 46 Yrs. 7 Mos. 8 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Mark Pickette

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Harriet Horton

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl Hemphill

(Address) 433 S. 9th.

15. Filed Oct 15 1920 R. H. Peace Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1920, to Oct 13 1920 that I last saw her alive on Oct 13 1920 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH was as follows:*

Exophthalmic goiter

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. H. Dallman M. D.

10/13 1920 (Address) Boise, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 16 1920

20. UNDERTAKER: Summers & Yates — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 31872
Registered No. 345

1. PLACE OF DEATH
County of Ada
City of Boise (No. 410, State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Hanover
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~ (Write the word.)

6. DATE OF BIRTH: Sept 7th 1905 (Month) (Day) (Year)

7. AGE: 15 Yrs. 1 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sumpter, Ore

10. NAME OF FATHER: Wm Hanover

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Celesta Levander

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A L Riggle
(Address) Boise, Idaho

15. Filed Oct 15 1920 R H Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 13th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1920, to Oct 13 1920, that I last saw h.im alive on Oct 13 1920, and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Gangrenous appendicitis and peritonitis.
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. R. Numbers M. D.
19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? St Alphonsus
Former or usual residence Boise, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Morris Hill — DATE OF BURIAL: Oct 16 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS:

Dr. Number

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31873

Registered No. 946

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 110 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ralph Edman Houston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1889 (Year)

7. AGE: 31 Yrs. 1 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lake View Oregon

10. NAME OF FATHER: Thomas B. Houston

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Millie Winger

13. BIRTHPLACE OF MOTHER (State or Country): Oregon

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jay. Houston

(Address) Robinette Ore

15. Filed Oct 17 1920 R H Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1920, to Oct 17 1920, that I last saw him alive on Oct 16 1920, and that death occurred on the date stated above, at 9 a. M.

The CAUSE OF DEATH* was as follows:

Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Carbuncle

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Smith M. D.

10/17 1920 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Council Ida — DATE OF BURIAL: Oct. 19 1920

20. UNDERTAKER: Dunsmoor & Krebs — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 R. 1-...

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31874

Registered No. 348

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St. Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice L. Ranke

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct 2 1920
(Month) (Day) (Year)

7. AGE: -- Yrs. -- Mos. 12 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): ********

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Ranke

11. BIRTHPLACE OF FATHER (State or Country): Oklahoma

12. MAIDEN NAME OF MOTHER: Lydia Baumen

13. BIRTHPLACE OF MOTHER (State or Country): No. Dakota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Ranke

(Address) Meridian Idaho.

15. Filed Oct 15 1920. R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 14 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1920 to Oct 1920 that I last saw h[illegible] alive on Oct 1920 and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows: Premature Birth (Asphyxia)

(Duration) ... Yrs. ... mos. 12 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Hubert F Neal M. D.

10-14 1920 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Oct 15 1920

20. UNDERTAKER: Summers & Krebs

ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31875
Registered No. 349

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 410 State St.)
Registration District No.
Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gale Vaught

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Male

6. DATE OF BIRTH: Dec (Month) 9 (Day) 1915 (Year)

7. AGE: 4 Yrs. 10 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: R. A. Vaught

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Ada Hester

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Vaught
(Address) 221 S 16 St.

15. Filed Oct 21 1920
P. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1920, to Oct 21 1920, that I last saw h im alive on Oct 20 1920, and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Streptococcus Laryngitis

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Bronchial pneumonia
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) M. D. Tallman M. D.
10/21 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 10/22 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Tallman

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31876

Registered No. 250

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 110 E Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane Vandeford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept 11 (Month) (Day) 1852 (Year)

7. AGE: 67 Yrs. 1 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Joseph Vanhorn

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Hommes

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Vandeford

(Address) St Lukes Hospital

15. Filed Oct 23 1920. R. E. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1st 1920 to Oct 20 1920 that I last saw h.r alive on Oct 20 1920 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Hypertrophy of heart, Hypostatic pneumonia

(Duration) yrs. mos. 2 ds.

(Signed) W. T. Adams M. D.

Oct 23 1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 23 1920.

20. UNDERTAKER: Summers & Hart — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

A & B

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3187

Registered No. 351

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1116 Idaho St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Twin Babys ~~Diers~~ Diers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Males

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 22nd (Day) 1920 (Year)

7. AGE: ——— Yrs. ——— Mos. ——— ds.

IF LESS than 1 day how many 2 hrs. or ——— min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Cycil C. Diers

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Lola Ellsworth

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C.C. Diers

(Address) 1116 Idaho St.

15. Filed Oct 23 1920 W.K. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1920 to Oct 22 1920 that I last saw him alive on Oct 21 1920, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ——— Yrs. ——— mos. ——— ds.

Contributory (Secondary)

(Duration) ——— yrs. ——— mos. ——— ds.

(Signed) R E Shuntz M. D.

Oct 22 1920. (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ——yrs.——mos.——days. In the State ——yrs.——mos.——days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: 10/23 1920

20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. Shuntz.

A & B

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3187

Registered No. 3-1

1. PLACE OF DEATH

County of Ada

City of Boise (No. 1116 Idaho St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Twin Babys ~~Diers~~ Diers

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Males	White	Single

6. DATE OF BIRTH Oct 22nd 1920
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. — ds.

IF LESS than 1 day how many 2 hrs. or — min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER Cycil C. Diers

11. BIRTHPLACE OF FATHER Ills (State or Country)

12. MAIDEN NAME OF MOTHER Lola Ellsworth

13. BIRTHPLACE OF MOTHER Idaho (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. C. Diers

(Address) 1116 Idaho St.

15.

Filed Oct 23 1920 R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 22nd 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21st 1920 to Oct 22nd 1920 that I last saw them alive on Oct 22 1920, and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R E Shuntz M. D.

Oct 22 1920. (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	10/23 1920

20. UNDERTAKER	ADDRESS
Schreiber & Sidenfaden	Boise, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. Shuntz.

Z

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31878
Registered No. 352

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 529 E. Bannock St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bertha Esther Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April 1 1872 (Month) (Day) (Year)

7. AGE: 48 Yrs. 6 Mos. 22 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Neb.

10. NAME OF FATHER: H. A. Alden

11. BIRTHPLACE OF FATHER (State or Country): Miss.

12. MAIDEN NAME OF MOTHER: Margarite Sanford

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Margaret N. Phillips

(Address) R 5 Boise,

15. Filed Oct 24 1920 R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 22 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1920 to Oct 22 1920 that I last saw h.r alive on Oct 22 1920, and that death occurred on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Obstruction bowel.

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) A. Abegglen M. D.

19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Boise, Idaho

19. PLACE OF BURIAL OR REMOVAL: Morris Hill

DATE OF BURIAL: 10/24 1920

20. UNDERTAKER: Schreiber & Sidenfaden

ADDRESS: Boise Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Higgs

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Boxton.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31879

Registered No. 353

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 410 W. State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah V. Hill

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Widow

6. DATE OF BIRTH: Aug. (Month) 5 (Day) 1857 (Year)

7. AGE: 63 Yrs. 2 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Kirby Hill

(Address) 2323 N. 16

15. Filed Oct 25 1920. R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1919, to Oct 23 1920, that I last saw her alive on Oct 13 1920, and that death occurred on the date stated above, at 2.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix Uteri

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary): Anaemia & Exhaustion

(Duration) yrs. 3 mos. ds.

(Signed) H. N. Braxton M. D.

Oct 23 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Oct 25 1920
20. UNDERTAKER	ADDRESS
Summers & Hicks	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31880

Registered No. 356

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 410 State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Ellen L. Shelton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct. 28 1860 (Month) (Day) (Year)

7. AGE: 59 Yrs. 11 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Del.

10. NAME OF FATHER: W. H. Pryor

11. BIRTHPLACE OF FATHER (State or Country): Del.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. R. Shelton

(Address) 522 So 13 St

15. Filed Oct 26 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1920 to Oct 24 1920 that I last saw h.r. alive on Oct 24 1920 and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis
and gall bladder
infection

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R. A. Higgs M. D.

Oct 25 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 27 1920

20. UNDERTAKER: Summers & Kirk — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Callista

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31881

Registered No. 357

1. PLACE OF DEATH

County of Ada.

City of

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 1 mi North Soldiers Home St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Strehle.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widower

6. DATE OF BIRTH: March 5 1841
(Month) (Day) (Year)

7. AGE: 79 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Merchant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Joseph Strehle.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Theresa Deng.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. S. Pratt Funeral Dir.
(Address) Boise Idaho

15.
Filed Oct 26 1920 R. N. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h... alive on ..... 19...,
and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Amick M. D.
Oct 26 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Oct 26 1920

20. UNDERTAKER: Summers & Webb.

ADDRESS: Boise Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31882

Registered No. 358

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 408 Logan St.)

2. FULL NAME Mary Mott

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: May (Month) 3 (Day) 1871 (Year)

7. AGE: 49 Yrs. 5 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: T. H. Berg

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Mary Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fannie Mott

(Address) 408 Logan

15. Filed Oct. 24 1920

P. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21 1920, to Oct 23 1920

that I last saw her alive on Oct 23 1920

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Emphysema with complications

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) P P French M. D.

10-24 1920 (Address) [redacted] Overland Bldg. Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Oct 27-1920.

20. UNDERTAKER: Summers & Tabb — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-19.

Gallman

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31883

Registered No. 3[illegible]

1. PLACE OF DEATH

County of Ada

City of Boise.

(No. 411 N. 10. St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fern F. Wicklund

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 22 (Day) 1907 (Year)

7. AGE: 13 Yrs. 9 Mos. 5 ds.

IF LESS than 1 day: how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student.
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Clarence P. Wicklund

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Ethel Davis.

13. BIRTHPLACE OF MOTHER (State or Country): Kansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Clarence P. Wicklund
(Address):

15. Filed Oct 27 1920 — R. H. Coate, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1920, to Oct 27 1920, that I last saw h[illegible] alive on Oct 26 1920, and that death occurred on the date stated above, at 20 M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) about Yrs. mos. 14 ds.

Contributory (Secondary) —

(Duration) yrs. mos. ds.

(Signed) O. O. Higgs M. D.

10-27-1920 (Address) 622 Warm St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL 19[illegible]

20. UNDERTAKER: Summers & Kibbe. — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____

Primary Registration District No. ____

File No. 31884

Registered No. ____

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mabel Ruth Dorland

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 5th (Day) 1901 (Year)

7. AGE: 19 Yrs. 5 Mos. 23 ds.

IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housekeeper

(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Brownell Kas.

10. NAME OF FATHER: Chas Adee

11. BIRTHPLACE OF FATHER (State or Country): Wis

12. MAIDEN NAME OF MOTHER: Gertie Renner

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ross Dorland

(Address) Nampa Idaho

15. Filed Oct 29 1920

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) – 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18th 1920, to Oct 28th 1920 that I last saw her alive on October 28 1920 and that death occurred on the date stated above, at ____ M.

The CAUSE OF DEATH* was as follows:

Acute Typhoid fever –

(Duration) Yrs. ____ mos. 17 – ds.

Contributory (Secondary) Anaemia

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. L. Dutton M. D.

10/29 1920 (Address) 1817 Resaque

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. 8 days. In the State 9 yrs. – mos. ____ days

Where was disease contracted if not at place of death? Nampa Idaho

Former or usual residence Nampa Idaho

19. PLACE OF BURIAL OR REMOVAL: Ashler Lawn Cemetery

DATE OF BURIAL: 10/30 1920

20. UNDERTAKER: Nampa La Schneider & Hidenbrand

ADDRESS: Boise Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr. Dutton

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31885
Registered No. 242

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. 616 Pierce St.)
Registration District No.
Primary Registration District No. 1004
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Engelman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed),

6. DATE OF BIRTH: — (Month) — (Day) 1872 (Year)

7. AGE: 48 Yrs. — Mos. — ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Rich.

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address) Lester Engelmans

15. Filed Oct 29 1920 R. H. Coate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 29 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 3A M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Uterus.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Carl Keil M. D.
(Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie Idaho. DATE OF BURIAL: Oct 30 1920

20. UNDERTAKER: Summers & Hebb. ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31886
Registered No. 354

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 1938 N. 17th St. St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME B. Frank Orr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male.	White	Married (Write the word.)

6. DATE OF BIRTH Nov - 28 - 1875
(Month) (Day) (Year)

7. AGE 44 Yrs. 10 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Mo.

10. NAME OF FATHER John Orr

11. BIRTHPLACE OF FATHER (State or Country) Va.

12. MAIDEN NAME OF MOTHER Elizabeth Smith

13. BIRTHPLACE OF MOTHER (State or Country) Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McE. Bratney

(Address) Boise, Idaho.

15. Filed Oct 24 1920. R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 22 - 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 12 1920, to Oct 22 1920, that I last saw h.sm. alive on Oct 21 1920, and that death occurred on the date stated above, at 10P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. T. Brewer M. D.

10/27 1920 (Address) E. T. Brewer Boise Idaho.

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. ~~LENGTH~~ OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery — **DATE OF BURIAL** 10/24 1920.

20. UNDERTAKER W. McE. Bratney — **ADDRESS** Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 11
(No. ..... St.)

File No. 31888
Registered No. 2
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Addie B. Cole

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Jan (Month) 24 (Day) 1[illegible] (Year)

7. AGE: 39 Yrs. 8 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Co Iowa

10. NAME OF FATHER: J S Dunham

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Elisia Blair

13. BIRTHPLACE OF MOTHER (State or Country): N J.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F O Johnson
(Address) Meridian Idaho

15. Filed 10-16 1920 Halbert F Hall
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1920 to Oct 14 1920 that I last saw her alive on Oct 14 1920 and that death occurred on the date stated above, at 8.50 A.M.

The CAUSE OF DEATH* was as follows:
Valvular heart lesion
(Mitral)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Halbert F. Hall M. D.
10-16 1920 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian Cemetery | DATE OF BURIAL: Oct 17 1920

20. UNDERTAKER: W S Motes | ADDRESS: Meridian

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31889

Registered No. 25

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 17

(No. St. Anthony Northern St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Elaine Criswell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: January (Month) 2 (Day) 1917 (Year)

7. AGE: 3 Yrs. 9 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: R. Allen Criswell

11. BIRTHPLACE OF FATHER (State or Country): Ottumwa Iowa

12. MAIDEN NAME OF MOTHER: Ose Harris

13. BIRTHPLACE OF MOTHER (State or Country): Old Beaver Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Garnet Criswell
(Address) Pocatello

15. Filed 10/4 1920

J. P. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1920 to Oct 2nd 1920 that I last saw her alive on Oct 2nd 1920, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

General peritonitis following ruptured appendix

(Duration) Yrs. mos. 7 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Asa Newton M. D.

Oct 4 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery — DATE OF BURIAL: Oct 5 1920

20. UNDERTAKER: W. P. Walker — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. (See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34891
Registered No. 3427

1. PLACE OF DEATH
County of Bannock
City or Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2 1 L
(No. One mile S. of Pocatello St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donald B. Clement

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 19th 1920 (Month) (Day) (Year)

7. AGE: Yrs. 5 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Ray Clement

11. BIRTHPLACE OF FATHER (State or Country): Neb—

12. MAIDEN NAME OF MOTHER: Catherine Foy

13. BIRTHPLACE OF MOTHER (State or Country): Neb—

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Clement
(Address) Pocatello Idaho

15. Filed 10/8 1920 J. P. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 7 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 5 1920 to Aug 7 1920 that I last saw him alive on Aug 7 1920, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:
Acute gastro enteritis

(Duration) ... Yrs. ... mos. 3 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) A M Newton M. D.
Aug 8 1920 (Address) Kamberly Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Interment Cird — DATE OF BURIAL: Aug 9 1920

20. UNDERTAKER: Thomas Hall — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2101
(No. General Hospital St.)

File No. 24892
Registered No. 3428

1. PLACE OF DEATH

County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dean Hyde Stoddard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Oct 8th 1920
(Month) (Day) (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many 11 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. W. Stoddard

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Maytle P. Hyde

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Stoddard
(Address) 436 N. 6th E.

15. Filed 10-1 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1920, to Oct 8 1920 that I last saw h.... alive on Oct 8 1920, and that death occurred on the date stated above, at about 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity

....(Duration) ....Yrs....mos....ds.

Contributory (Secondary)

....(Duration) ....yrs....mos....ds.

(Signed) [illegible] M. D.

10-2 1920 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View | DATE OF BURIAL: Oct 1920

20. UNDERTAKER: Schumacher Bros | ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

28

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No.

City of Pocatello Primary Registration District No. 2161 File No. 23055

(No. St Anthony Hospital) Registered No. 3429

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant DeSchweinitz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct 9th 1920
(Month) (Day) (Year)

7. AGE: Premature Birth
Yrs. Mos. ds.

IF LESS than 1 day how many 3 hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A A DeSchweinitz

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary E. Barton

13. BIRTHPLACE OF MOTHER (State or Country): Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A A DeSchweinitz
(Address) Pocatello Idaho

15. Filed 10/11 1920 J. T. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 10 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1920, to Oct 10 1920, that I last saw her alive on Oct 9 1920, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity - 5 mo.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J M Mary M. D.

10/10 1920 (Address) Pocatello, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Oct 10th 1920

20. UNDERTAKER: D Schumacher Hdq — ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5 25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2141
(No. 1 N Lander St.)

File No. 34893
Registered No. 34431
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Payne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Aug (Month) 9 (Day) 1875 (Year)

7. AGE: 45 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Fletcher Heather

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Payne
(Address) Pocatello Ida

15. Filed 10 18 1920 W. L. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1920 to Oct 17th 1920 that I last saw her alive on Oct 16 1920 and that death occurred on the date stated above, at 12-45 P. M.

The CAUSE OF DEATH* was as follows:
probably Diabetes Mellitus
Sans patient but
one.
(Duration) Yrs. 8 mos. 5 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) D. C. Ray M. D.
10-17 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Cemetery — DATE OF BURIAL: 10/19 1920

20. UNDERTAKER: [illegible] — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31897

Registered No. 3434

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2141

(No. General Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Don Thomas Kellow

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: August (Month) 7 (Day) 1919 (Year)

7. AGE: 1 Yrs. 7 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: Thomas Kellow

11. BIRTHPLACE OF FATHER (State or Country): Butte Montana

12. MAIDEN NAME OF MOTHER: Vina Ross

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Kellow

(Address) 541 E. Johnson

15. Filed 10/20 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 9th 1920 to Oct. 18 1920

that I last saw him alive on Oct. 18 1920

and that death occurred on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Infectious Diarrhoea

Enteritis

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary) Septicemia

(Duration) yrs. mos. 9 ds.

(Signed) J. M. Sprague M. D.

10.20 1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 5 days. In the State 1 yrs. 2 mos. 11 days

Where was disease contracted if not at place of death? 541 E. Johnson

Former or usual residence 541 E. Johnson

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: Oct 20 1920

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31898

Registered No. 3436

Registration District No. 28

Primary Registration District No. 1716

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. Lynn Apts Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Harvey Hubbell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH Aug (Month) 19 (Day) 1883 (Year)

7. AGE 37 Yrs. 2 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Arkansas

10. NAME OF FATHER Asa Hubbell

11. BIRTHPLACE OF FATHER (State or Country) New York

12. MAIDEN NAME OF MOTHER Annie McGomery

13. BIRTHPLACE OF MOTHER (State or Country) Mississippi

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Hubbell
(Address) Pocatello Ida

15. Filed 10/22 1920 J. P. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13, 1920 to Oct 21, 1920 that I last saw he alive on Oct 21, 1920 and that death occurred on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Embolism

10 minutes (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Operated for Ruptured appendix

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. W. Lynn M. D.

Oct 22 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lakeside Texas Co Mo. | DATE OF BURIAL 10/23 1920

20. UNDERTAKER W. T. Barker | ADDRESS Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

(No.) St. Anthony Hospital (St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34899

Registered No. 3437

1. PLACE OF DEATH

County of Bannock

City or Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Hamilton Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Female	White	Married

6. DATE OF BIRTH Nov. 7 1889
(Month) (Day) (Year)

7. AGE 30 Yrs. 11 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Geo. Hamilton

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Hannah Mahee

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. W. Jones

(Address) Pocatello Ida

15. Filed 10-22 1920

J. Thomas Myers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 19 1920 to Oct. 21 1920 that I last saw h[illegible] alive on Oct 21 1920 and that death occurred on the date stated above, at 11 30 M.

The CAUSE OF DEATH was as follows:

Erysipelas

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R. S. Bowell M. D.

Oct 22 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Riverview

DATE OF BURIAL Oct 24 1920

20. UNDERTAKER Chamberlin Hale

ADDRESS City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31900

Registered No. 3938

1. PLACE OF DEATH
County of Bannock
City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 1/2/61
(No. Lynn Burr Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josie Vidal

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1895 (Year)

7. AGE: 25 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: /

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Morris Chacon
(Address) Pocatello Ida.

15.
Filed 10/25 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1920 to Oct 23 1920
that I last saw him alive on Oct 23 1920
and that death occurred on the date stated above, at 1 P.M.
The CAUSE OF DEATH* was as follows:

Gun Shot wound
of the abdomen
(Duration) Yrs mos. 1 hrs ds.
Contributory (Secondary) Peritonitis
(Duration) 1 yrs. mos. 13 hrs ds.

(Signed) J. J. Ferguson M. D.
10-25-20 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs. 1 mos 13 days

Where was disease contracted if not at place of death? —

Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL: New Cemetery
DATE OF BURIAL: 10/26 1920

20. UNDERTAKER: W. D. Wacker
ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 6-25 M. 1 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31901

Registered No. 3439

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 1267

(No. Lynn Boro Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Pete Mellivanced

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Single

6. DATE OF BIRTH: June (Month) (Day) 1887 (Year)

7. AGE: 33 Yrs. Mos. da.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: /

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daisy Deuce

(Address) Pocatello

15. Filed 10/26 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 24 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1920 to Oct 24 1920 that I last saw h[illegible] alive on Oct 24 1920 and that death occurred on the date stated above, at 1.30 M.

The CAUSE OF DEATH* was as follows:

Gun wound Thro left lung & stomach

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

Oct 26 1920 (Address) Pocatello Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: [illegible] Cemetery — DATE OF BURIAL: 10/27 1920

20. UNDERTAKER: [illegible] Walker — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 241
File No. 32902
Registered No. 3446

1. PLACE OF DEATH

County of Bannock.
City of Pocatello.
(No. 544 N Arthur St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Williams.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH Oct. (Month) 24 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Pocatello Ida

10. NAME OF FATHER John W. Williams

11. BIRTHPLACE OF FATHER (State or Country) Idaho.

12. MAIDEN NAME OF MOTHER Rosamond Green

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W Williams
(Address) 544 N Arthur

15. Filed 1-28 1920.
J. Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 28 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 24 1920 to Oct 28 1920
that I last saw h[illegible] alive on Oct 27 1920
and that death occurred on the date stated above, at 7 A.M.
The CAUSE OF DEATH* was as follows:
Premature 7 mo gestation

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Howard M. D.
10/28 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mt View Cemetery	Oct 29 1920.

20. UNDERTAKER	ADDRESS
A. L. McHan	Pocatello Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 241
File No. 31903
Registered No. 3441

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. Lyons Bros Hospital St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Catina Paul Vanval Kenbruge

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct 1 (Month) (Day) 1865 (Year)

7. AGE: 55 Yrs. 1 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pleasant Utah

10. NAME OF FATHER: Edward Dalley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: /

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Vanval Kenbruge
(Address) Pocatello Ida

15. Filed 10/31 1920 J. H. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 29 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1920 to Oct 29 1920 that I last saw her alive on Oct 29 1920 and that death occurred on the date stated above, at 10-30 P. M.
The CAUSE OF DEATH* was as follows:
Apoplexy

(Duration) Yrs. mos. 4h ds.
Contributory (Secondary) none
(Duration) yrs. mos. ds.

(Signed) Dr Lyons M. D.
Oct 31 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah
DATE OF BURIAL: 11/1 1920

20. UNDERTAKER: W. R. Parker
ADDRESS: Pocatello Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31904

Registered No. 3442

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2101

(No.) Lynn Ave. (St.)

2. FULL NAME Robert T Brown.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 17 (Day) 1903 (Year)

7. AGE: 16 Yrs. 9 Mos. 19 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Boy.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Black Foot Ida

10. NAME OF FATHER: T. D Brown Jr.

11. BIRTHPLACE OF FATHER (State or Country): East Salt Lake City

12. MAIDEN NAME OF MOTHER: Cordelia Davis

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. D Brown Jr.

(Address) Black Foot Ida.

15. Filed 10/31 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1920, to Oct 31 1920, that I last saw him alive on Oct 31 1920, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

General peritonitis

(Duration) ..... Yrs. ..... mos. 29 ds.

Contributory (Secondary) Ruptured appendix

(Duration) 11 days Yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Oct 31 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 17 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Black Foot Ida. DATE OF BURIAL: Oct 31 1920

20. UNDERTAKER: P. W. Walker ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

31905

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 216

(No. 1235 So. 5th Ave.)

File No.

Registered No. 912

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elaine Guthrie

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: May 6 1919
(Month) (Day) (Year)

7. AGE: — Yrs. 10 Mos. 26 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello, Ida.

10. NAME OF FATHER: Clifford Guthrie

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Lena Kelly

13. BIRTHPLACE OF MOTHER (State or Country): Indian territory

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clifford Guthrie

(Address) 1235 So. 5th Ave. Pocatello

15. Filed Oct 2 1920

J R Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 2 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2. 1:30 a.m. 1920, to death 1920, that I last saw h— alive on 1920, and that death occurred on the date stated above, at 4:20 a.m.

The CAUSE OF DEATH* was as follows:

Abcess of brain of two days duration

(Duration) Yrs. mos. ds.

Contributory (Secondary) Convulsions

(Duration) yrs. mos. ds.

(Signed) G. J. Parker M.D. M. D.

Oct 2 1920 (Address) Cor Cen & Drug Store

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Pocatello, Idaho

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem

DATE OF BURIAL: Oct 2 1920

20. UNDERTAKER: H L McHan

ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31906

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
(No. ..... St.)
File No. 36
Registered No. 3433

1. PLACE OF DEATH
County of Bannock.
City of Pocatello.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas S Pheltman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): divorced

6. DATE OF BIRTH: Sept (Month) 3 (Day) [illegible] (Year)

7. AGE: 30 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroad Engineer
(b) General nature of industry, business or establishment in which employed (or employer): Oregon Short Line

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Robert B Pheltman

11. BIRTHPLACE OF FATHER (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Maggie E Laney

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert B Pheltman
(Address) Pocatello Ida.

15. Filed 10 - 20 1920
J R Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cause of Death unknown, man was found dead in Rooming house, been dead several hours, pod. mortem showed nothing, cause probably Homicide.
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
Oct. 10 1920. (Signed) F. M. Williams M. D.
(Address) County Corner.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence: Pocatello Ida.

19. PLACE OF BURIAL OR REMOVAL: Mt View Cemetery. DATE OF BURIAL: Oct 20 1920.

20. UNDERTAKER: [illegible] McHan. ADDRESS: Main & Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31907

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2161
File No. 36
Registered No. 3435

1. PLACE OF DEATH
County of Bannock,
City of Pocatello,
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank E. Shepherd.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: August (Month) 19 (Day) 1882 (Year)

7. AGE: 38 Yrs. 1 Mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Train dispatcher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio.

10. NAME OF FATHER: Geo W Shepherd.

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Margaret Clegg

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. A. Hoover.
(Address) Blackfoot.

15. Filed 10-20- 1920
J. R. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1920 to Oct 18 1920, that I last saw h[illegible] alive on Oct 18 1920, and that death occurred on the date stated above, at 2.55 P. M.

The CAUSE OF DEATH* was as follows:

Paresis.

(Duration) ..... Yrs., ... mos. ..... ds.

Contributory (Secondary) Specific

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Hoover, M. D.

(Address) Blackfoot Ida.

Oct 19 1920.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
State Insane Asylum Blackfoot Ida.

Where was disease contracted if not at place of death? Can't say.

Former or usual residence Pocatello Ida. 14 yrs.

19. PLACE OF BURIAL OR REMOVAL: Pocatello
DATE OF BURIAL: Oct 21 1920.

20. UNDERTAKER: H. L. McStan.
ADDRESS: 215 So Main St.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31908

Registered No.

1. PLACE OF DEATH

County of Bannock

City of Arimo

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No.

(No. Arimo Idaho St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eleanor Tippets

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: July 20 1840 (Month) (Day) (Year)

7. AGE: 80 Yrs. 3 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Thomas Wise

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Phibe Harton

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H W Tendrum

(Address) Arimo

15. Filed 11 — 5 — 1920

J. H. Partridge
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 26 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1920, to Oct. 26, 1920 that I last saw her alive on Oct. 21, 1920 and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Cirtosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Partridge M. D.

Oct. 28 1920 (Address) Downey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Farmington Utah — DATE OF BURIAL: Oct 29 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31909

Registration District No. 83

Primary Registration District No.

(No. ..... St.)

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME June Hewey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	

6. DATE OF BIRTH

July (Month) 7 (Day) 1920 (Year)

7. AGE

Yrs. ..... Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Downey Idaho.

10. NAME OF FATHER Ashley Hewey

11. BIRTHPLACE OF FATHER (State or Country) Downey, Idaho.

12. MAIDEN NAME OF MOTHER Vera M. Coffin

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ashley Hewey

(Address) Downey, Idaho.

15. Filed July, 24, 1920 A. E. Barbrigier Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

July (Month) 23, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July, 20, 1920 to July, 23, 1920 that I last saw h.im alive on July 23, 1920, and that death occurred on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:

acute Enteric Intoxication

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. E. Barbrigier M. D.

7-24 1920 (Address) Downey Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Downey, Idaho	7-24, 1920
20. UNDERTAKER	ADDRESS
C. E. Sayton	Downey.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 83
Primary Registration District No.
(No. ..... St.)

File No. 31910
Registered No. .....

1. PLACE OF DEATH.
County of Bannock
City of Downey
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Olive May Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
2 (Month) 14 (Day) 1888 (Year)

7. AGE
32 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework at home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Utah

10. NAME OF FATHER Edmond J Brown

11. BIRTHPLACE OF FATHER
(State or Country) Utah

12. MAIDEN NAME OF MOTHER Olive Jane Bottleson

13. BIRTHPLACE OF MOTHER
(State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. A. Swenson
(Address) Downey, Ida.

15.
Filed 5-20-1920
H. J. Partridge
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 16 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 9, 1920, to May 16, 1920, that I last saw h.s.r. alive on May 9, 1920, and that death occured on the date stated above, at 8:00 A.M.

The CAUSE OF DEATH* was as follows:
Epilepsy.
Chronic valvular disease of heart.
(Duration) 3/ Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Partridge M. D.
5-19-1920 (Address) Downey

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Downey
DATE OF BURIAL: 5-19-1920

20. UNDERTAKER: C E Layton
ADDRESS: Downey Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SONS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No.

(No. , St.)

File No. 31911

Registered No.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roella A Hengreen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH

Aug (Month) 24 (Day) 1920 (Year)

7. AGE

5 yrs. 11 mos. 29 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Carl A Hengreen

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Elva R Brown

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Carl A Hengreen

(Address) Downey Idaho

15.

Filed Aug. 26, 1920

H J Hartwigsen
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Aug (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 16 1920 to Aug. 24, 1920 that I last saw her alive on Aug. 24, 1920 and that death occurred on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows:

Hip Pathema

.....(Duration) .....yrs. .....mos. 8 ds.

Contributory (Secondary) None

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) H J Hartwigsen, M. D.

Aug 25 1920 (Address) Downey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Downey	Aug 25 1920

20. UNDERTAKER	ADDRESS
L E Layton	Downey

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Swan Lake

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No.

(No. , St.)

File No. 31912

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leona Hatch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept (Month) 25 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Daniel George Hatch

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elsie May Gooch

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel George Hatch

(Address) Swan Lake, Idaho

15. Filed Sept., 30, 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1920, to Sept 25 1920, that I last saw her alive on Sept 25 1920, and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:

7 mos. gestation

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Curtis Hand M. D.

9/26/1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: + Oxford Ida. — DATE OF BURIAL: 9-27 1920+

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31913

Registered No.

Registration District No. 83

Primary Registration District No.

1. PLACE OF DEATH

County of Bannock

City of Arimo (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Nelson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Aug 3 1847
(Month) (Day) (Year)

7. AGE: 73 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Martin R Petersen

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mary Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): H L Bittner
(Address): Arimo Idaho

15.
Filed Oct-5-1920 J H Torrington
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 2 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 5, 1920 to Oct. 3, 1920 that I last saw h[illegible] alive on Oct. 1, 1920, and that death occurred on the date stated above, at 9:05 A.M.

The CAUSE OF DEATH* was as follows:
Cerebral hemorrhage.
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Arterio-sclerosis
(Duration) 3 yrs. mos. ds.

(Signed) H H Torrington M. D.
10-3-1920 (Address) Downey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 2 yrs. mos. days. In the State 50 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Weston, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Weston Idaho
DATE OF BURIAL: Oct 4 1920

20. UNDERTAKER: Schumacher Bros
ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31914

1. PLACE OF DEATH.
County of Bannock
City of Virginia
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83
Primary Registration District No.
(No. ..... St.)

2. FULL NAME Thomas R Bennett

Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH: Mar (Month) 18 (Day) 1863 (Year)

7. AGE: 57 yrs. 6 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kaysville Utah

10. NAME OF FATHER: Thomas Bennett

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Maria Driggs

13. BIRTHPLACE OF MOTHER (State or Country): Ill Hancock Co

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Catherine Bennett
(Address) Virginia Idaho

15.
Filed Oct 6 1920. H. Hawgin
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: ~~August~~ Oct (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 6, 1920, to Aug. 25, 1920 that I last saw him alive on Aug. 25, 1920, and that death occurred on the date stated above, at 3 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.
Contributory (Secondary) 3
(Duration) yrs. mos. ds.

(Signed) H. Hawgin M. D.
Oct 5 1920 (Address) Downey, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: Oct 5 1920

20. UNDERTAKER: La E Layton — ADDRESS: Downey

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31915
Registered No. .....

1. PLACE OF DEATH.
County of Bannock
City of Downey
(No. ....., ... St.)
Registration District No. 83
Primary Registration District No. .....
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Irvin M Burrup

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Nov (Month) 29 (Day) 1896 (Year)
7. AGE: 23 Yrs. 6 Mos. 23 ds.
IF LESS than 1 day how many .....hrs. or .....min.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: John Burrup
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Elsie E Shurtliff
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Burrup
(Address) Downey
15. Filed June 24, 1920 — Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 22 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 5 1920, to June 17 1920, that I last saw him alive on June 17 1920, and that death occured on the date stated above, at 3 M.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
.....(Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) Rheumatic Fever
.....(Duration ..... yrs. 2 mos. ..... ds.
(Signed) H. Partridge M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Downey — DATE OF BURIAL: June 24 1920
20. UNDERTAKER: C E Taylor — ADDRESS: Downey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31916

Registered No. .....

Registration District No. 83

Primary Registration District No. .....

(No. ....., ... St.)

1. PLACE OF DEATH.

County of Bannock

City of Downey

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rissie S Horton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. May (Month) 9 (Day) 1902 (Year)

7. AGE: 38 Yrs. 11 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... House Wife

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER John M Skaggs

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Sebra Fourtjison

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) C H Horton

(Address) Downey

15. Filed July 12 1920

H Harrington
Local Registrar

SVMS - YORK CO., PTRS. & BOBS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 5, 1920, to July 9, 1920, that I last saw her alive on July 9, 1920, and that death occured on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH* was as follows:

Sepsis Puerperarum and abortion.

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Harrington M. D.

19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: C E Layton Downey — DATE OF BURIAL: July 12 1920

20. UNDERTAKER: C E Layton — ADDRESS: Downey

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 31918
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Lund
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fenby Ross Hansen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: Oct. 3rd, 1920 (Month) (Day) (Year)

7. AGE: ...Yrs...Mos...ds. IF LESS than 1 day how many...hrs. or 7 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lund Idaho.

10. NAME OF FATHER: Erastus S. Hansen

11. BIRTHPLACE OF FATHER (State or Country): Logan Utah

12. MAIDEN NAME OF MOTHER: Mary S. Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Brigham City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) (sgn). Erastus S. Hansen
(Address) Lund Idaho.

15. Filed ...19...
O. Pinkerton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 3rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 3rd 1920, to Oct. 3rd, 1920 that I last saw h. im alive on Oct. 3rd 1920, and that death occurred on the date stated above, at 2.22 P. m.

The CAUSE OF DEATH* was as follows:
Premature birth. (six months).

...(Duration) ...Yrs...mos. 1 ds.
Contributory (Secondary) congenital atelectasis.
...(Duration) ...Yrs...mos. 1 ds.

(Signed) Owen V. Pinkerton M. D.
10/3/ 1920. (Address) Bancroft Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lund Idaho.	10/3/ 1920.
20. UNDERTAKER: father	ADDRESS: Lund Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 31919
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Bancroft
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Virginia Ruger.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	single

6. DATE OF BIRTH
November 30th, 19[illegible]
(Month) (Day) (Year)

7. AGE
Yrs. 10 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Bancroft Idaho.

10. NAME OF FATHER Eugene Ruger

11. BIRTHPLACE OF FATHER (State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Elnora Grant

13. BIRTHPLACE OF MOTHER (State or Country) Chesterfield Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eugene Ruger(sgn). father
(Address) Bancroft Idaho.

15. Oct 5.
Filed ..... 19.....
O W Linhurst.
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October 17th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 10th 1920, to Oct. 17th 1920
that I last saw her alive on Oct. 17th 1920
and that death occurred on the date stated above, at 9.05 A.M.

The CAUSE OF DEATH* was as follows:
Chlorea infantum

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) paralytic ileum
(Duration) ..... Yrs. ..... mos. 2 ds.

(Signed) Owen V. Linhurst. M. D.
10/18 1920 (Address) Bancroft Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Chesterfield Idaho	10/20 1920
20. UNDERTAKER father	ADDRESS Bancroft Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31921

Registered No.

1. PLACE OF DEATH

County of Bear Lake.

City of Paris

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Hasenfratz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: (Month) Aug. (Day) 7 1837 (Year)

7. AGE: Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: Joseph Zimmerman

11. BIRTHPLACE OF FATHER (State or Country): Dont Know.

12. MAIDEN NAME OF MOTHER: Zimmerman

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Charles Wyler.

(Address) Paris - Idaho.

15. Filed 11/10/20 W. J. Sunson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: (Month) Oct. (Day) 26 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,

that I last saw h... alive on ..... 19...,

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Senusal Debility.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Charles A. Wyler M. D.

10/28/20 (Address) Paris Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Paris. DATE OF BURIAL: Oct 28 1920

20. UNDERTAKER: Bishop Low ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 236
File No. 31922
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Dingle
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Humphreys

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 12 (Day) 1864 (Year)

7. AGE: 56 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John McClifton

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Hannah Pettingen

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Humphreys
(Address) Dingle

15. Filed 10-25-1920 N. W. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1920 to July 10 1920
that I last saw her alive on July 1 1920
and that death occurred on the date stated above, at 11 M.
The CAUSE OF DEATH* was as follows:
Carcinoma of liver
Intestines

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Geo. Cudley M. D.
7-11 1920 (Address) Montpelier Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dingle Ida — DATE OF BURIAL: July 12 1920

20. UNDERTAKER: George Hawkes Bishop Mortuary — ADDRESS: Dingle

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 52

Primary Registration District No. 2136

File No. 31923

Registered No.

County of Bear Lake

City of Montpelier (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Ann Dunn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: 1 (Month) 31 (Day) 1836 (Year)

7. AGE: 84 yrs. 7 mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): U.S.

10. NAME OF FATHER: William Maguire

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse Dunn
(Address) Montpelier Ida

15. Filed 10-28-1920 N. Kling Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 8 (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased ~~from~~ M
July 30th 1920, to — 191 ,
that I last saw her alive on July 30th 1920
and that death occurred on the date stated above, at 9:15 a. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) — yrs. — mos. 7 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) C. F. Simpson M. D.

8-3 1920 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bennington

DATE OF BURIAL: Aug 5 1920

20. UNDERTAKER: F. M. Williams

ADDRESS: Montpelier, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Bear Lake
City of Geneva Ida
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 07
Primary Registration District No. 2136.
(No. ..... St.)

File No. 31924
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvin Parsons.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Child

6. DATE OF BIRTH April 19 16.
(Month) (Day) (Year)

7. AGE 4 Yrs. 4 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE Ft. Raymond, Idaho.
(State or Country)

10. NAME OF FATHER Edgar Parsons.

11. BIRTHPLACE OF FATHER New York. (State or Country)

12. MAIDEN NAME OF MOTHER Annie Miller.

13. BIRTHPLACE OF MOTHER England.
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George R. Hall
(Address) Raymond Idaho

15. Filed 10-28-19 20 E. H. Haws
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Aug 24th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 19 20 to Aug 24 19 20
that I last saw h.. alive on Aug 24 19 20
and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Acute Dilation.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) E. H. Haws M. D.
Aug 25 1920 (Address) Montpelier Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Geneva Ida — DATE OF BURIAL 8-27 1920

20. UNDERTAKER E. H. Haws. — ADDRESS Montpelier Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2132
File No. 1565
Registered No. 31925

1. PLACE OF DEATH.
County of Bear Lake.
City of Montpelier.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Orval K. Larsen.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: March (Month) 3 (Day) 1917 (Year)

7. AGE: 3 yrs. 5 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: H. Kenneth Larsen.

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Marion Fenstermaker.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H K Larsen
(Address) Montpelier Ida.

15. Filed 10-28 1920. H K Kinney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: May (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 26 1920 to May 27 1920 that I last saw h... alive on May 27 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Appendicitis Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. E. Buckley M. D.

8-23 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Georgetown. DATE OF BURIAL: Aug 29 1920

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2-136
File No. 31926
Registered No.

1. PLACE OF DEATH.
County of Bear Lake.
City of Montpelier (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Maria B. Mrs. Allemann

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Widowed~~ Single

6. DATE OF BIRTH: March (Month) 3 (Day) 1844 (Year)

7. AGE: 76 yrs. 5 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Christian Tenth

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Catharine Allemann

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Wm Severns Jr.
(Address) Montpelier, Idaho.

15.
Filed 10-25-1920 N. H. Kemp
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: August (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 191.., to Aug 26 191.., that I last saw h.. alive on ..... 191.., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pneumonia
Senile Decay
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. H. Kemp M. D.
Aug 1 19 20 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier, Idaho | DATE OF BURIAL: Aug. 29, 1920

20. UNDERTAKER: F. M. Williamson | ADDRESS: Montpelier Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5 r
Primary Registration District No. 2136
File No. 31927
(No. ..... St.)
Registered No. .....

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Boyd. George

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 1 (Day) 9?? (Year)

7. AGE: 8 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Schoool
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Parley P. George.

11. BIRTHPLACE OF FATHER (State or Country): New Mexico

12. MAIDEN NAME OF MOTHER: Rita Phelps.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy George
(Address) Montpelier Ida

15. Filed 10-25- 1920 N. A. Rees
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1920 to Oct. 4, 1920 that I last saw him alive on Oct. 4, 1920 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Acute apendicitis
(with Pus)
(Duration) 1 Yrs. ..... mos. 6 ds.
Contributory (Secondary) peritonitis
(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) George F. Ashley M. D.
Oct 11 1920 (Address) per Attendant, montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Montpelier, Ida.

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida
DATE OF BURIAL: Oct 6 1920

20. UNDERTAKER: J. M. Williams
ADDRESS: Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31928
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 5 B R Sutton

County of Bear Lake Primary Registration District No. 2132

City of Paris (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David E. Johnson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 11 (Day) 1886 (Year)

7. AGE: 34 Yrs. 2 Mos. 10 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Peter Johnson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER Matilda Brown

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. Johnson
(Address) Garden City, Utah

15. Filed 10/30/20 191.... W. R. Sutton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1920 to Oct 27 1920, that I last saw h.. alive on Oct 20 1920 and that death occured on the date stated above, at 3.05 P.M.

The CAUSE OF DEATH* was as follows:
1. Chr. Parenchymatous Nephritis.
2. Auto-Intoxication, Intestinal & Gentio Urinary. 2. Stasis, Intestines & Bladder

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. O. Moore M. D.
Oct 27 1920 (Address) Paris Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Removal. DATE OF BURIAL: Oct 27 1920

20. UNDERTAKER: Bishop Roper ADDRESS: Garden City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24654

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31929

Registered No. ____

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 52

Primary Registration District No. 2136

County of Bear Lake

City of Montpelier (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James S. Shaffer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: Sept 7 1920 (Month) (Day) (Year)

7. AGE: ____ yrs. ____ mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Wyoming

10. NAME OF FATHER: George S Shaffer

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Sadie Francis

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs G S Shaffer

(Address) Dingle Wyoming

15. Filed 10-25- 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 5 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1920 to Oct 5 1920 that I last saw h[illegible] alive on Oct 4 1920 and that death occurred on the date stated above, at 8 9 P. M.

The CAUSE OF DEATH* was as follows:

Acute Gastro-enteritis

(Duration) ____ yrs. ____ mos. 5 ds.

Contributory (Secondary) ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C. P. Gaulke M. D.

10-8 1920 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days.

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: Oct. 7 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31930
Registered No. .....

1. PLACE OF DEATH.
County of Benewah
City of Plummer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME Bernice Iowa Bruning

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec (Month) 12 (Day) 1912 (Year)

7. AGE: 8 Yrs. 10 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Schoolgirl
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Wash

10. NAME OF FATHER Clarence A Bruning

11. BIRTHPLACE OF FATHER (State or Country) Nebr

12. MAIDEN NAME OF MOTHER Mary Reddingshafer

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) L A Bruning
(Address) Colfax Wn

15.
Filed ..... 191.....
Local Registrar

BYNUM - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1920, to Oct 30 1920, that I last saw her alive on Oct 30 1920 and that death occured on the date stated above, at 5 9 M.

The CAUSE OF DEATH* was as follows:
Measles
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Pneumonia
(Duration ..... yrs. ..... mos. 3 ds.

(Signed) J. A. Nelson M. D.
10/30 1920 (Address) Deloa, Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Colfax Wn — DATE OF BURIAL: Oct 30 1920

20. UNDERTAKER: L A Bruning — ADDRESS: Colfax

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 31931
Registered No. 23

1. PLACE OF DEATH
County of Bonneville
City of Dewet
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Coyotie

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	Indian	Married

6. DATE OF BIRTH
(Month) (Day) 1829 (Year)

7. AGE
91 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Little Coyotie

11. BIRTHPLACE OF FATHER (State or Country): Washington

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles L. Mansfield
(Address) Tetonia - Idaho

15.
Filed Oct 14 1920
J. E. Bilhan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Senility
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) No doctor attended M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dewet	Oct 14 1920

20. UNDERTAKER	ADDRESS
J. Falcon	Dewet

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31932
Registered No. 49

1. PLACE OF DEATH

County of Benewah
City of St Maries
(No. ....., ... St.)
Registration District No. 32
Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cate Titus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Oct (Month) 19 (Day) 1842 (Year)

7. AGE: 78 Yrs. — Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Town of Hamburg N.Y.

10. NAME OF FATHER: Von Courter

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Lede Courter

13. BIRTHPLACE OF MOTHER (State or Country): Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cora Harvey
(Address) 425 E Everett Ave Spokane

15. Filed Oct. 28 1920
S H E Kent
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20 1920, to Oct 28 1920, that I last saw her alive on Oct 28 1920, and that death occurred on the date stated above, at 2 1/2 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy - Cerebral Hemorrhage following

(Duration) — Yrs. — mos. 8 ds.

Contributory (Secondary) old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C J Kinnaching M. D.

10/29 1920 (Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wood Lawn — DATE OF BURIAL: 10/29 1920

20. UNDERTAKER: St E Hunt Co — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31988

Registered No. 48

1. PLACE OF DEATH

County of Benewah

City of Chatcolet

(No. ..... St.)

Registration District No. 52

Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Bulmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 2 (Day) 1884 (Year)

7. AGE: 36 Yrs. 9 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Bridge Foreman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. J.

10. NAME OF FATHER: Howard Bulmer

11. BIRTHPLACE OF FATHER (State or Country): N. J.

12. MAIDEN NAME OF MOTHER: Emma Chamberlain

13. BIRTHPLACE OF MOTHER (State or Country): N. J.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) H L Alcorn

(Address) St Maries

15. Filed Oct. 24 1920 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows: 9 1/50

Accidental shooting while hunting ducks

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. L. Alcorn Coroner M. D.

Oct 24 1920 (Address) St Maries, Benewah Co, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rockford Wash. DATE OF BURIAL: 10/26 1920

20. UNDERTAKER: H Hunt Co ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 31934
Registered No. 47

1. PLACE OF DEATH
County of Benewah
City of Fernwood (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leo Vincent Coy
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
April 5 1916
(Month) (Day) (Year)

7. AGE
4 Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work X
(b) General nature of industry, business or establishment in which employed (or employer) X

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER John F Coy

11. BIRTHPLACE OF FATHER (State or Country) Canadian

12. MAIDEN NAME OF MOTHER Mary R Reilly

13. BIRTHPLACE OF MOTHER (State or Country) No Dacotas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leo L Reilly
(Address) Fernwood

15. Filed Oct 7 1920 H E Hunt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct. 6 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 4 10 P.M.

The CAUSE OF DEATH* was as follows:
Accidently killed by
Log rolling and Crushing
& Spinal
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Alcorn Coroner M. D.
10/7/1920 (Address) St Maries Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Coeur d Alene	19.....

20. UNDERTAKER	ADDRESS
H E Hunk Co	St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
(No. ....., ... St.)

File No. 31936
Registered No. 39

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lura Albertine Vidor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
June 14 1842
(Month) (Day) (Year)

7. AGE
78 Yrs. 4 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: James McCarthy

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Sarah Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. V. Johnson
(Address) Aberdeen Ida

15. Filed Oct 19 20 McMartin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct 18 20
(Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 4 1920, to Oct 18 1920, that I last saw h[er] alive on Oct 18 191 20, and that death occured on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Pneumonia Lobar

(Duration) Yrs. 1 mos. 14 ds.
Contributory (Secondary) Myocarditis
(Duration yrs. mos. 3 ds.

(Signed) M. C. McMartin M. D.
Oct 15 1920 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 2 mos. ....days. In the State ....yrs. 2 mos. ....days
Where was disease contracted if not at place of death? at home / death
Former or usual residence California

19. PLACE OF BURIAL OR REMOVAL: Ontario Calif. | DATE OF BURIAL: 10/23 191 20

20. UNDERTAKER: R M Lenhardt | ADDRESS: Aberdeen Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 116

Primary Registration District No. 2155

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34937

Registered No. 36

1. PLACE OF DEATH.

County of Bingham

City of Aberdeen

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernadetta Anna Jakszy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. nov 11 1915 (Month) (Day) (Year)

7. AGE: 4 Yrs. 10 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: David F Jackson.

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Isabelle missler

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant): D F Jackson

(Address): Aberdeen Ida

15. Filed oct 9 20 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: oct 8 20 (Month) (Day) 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from oct 8 191 20, to oct 8 191 20, that I last saw h[illegible] alive on oct 8 191 20, and that death occured on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

An accident -
Shock and bruises

1 hr.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Mrs Mary Jackson M. D.

10/8 19 20 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Ida — DATE OF BURIAL: 10/10 20 191

20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. [illegible] No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
(No. ....., ... St.)

File No. 31938
Registered No. 37

1. PLACE OF DEATH.
County of Bingham
City of Sterling
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel August Gilling
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Jan 25 1862 (Month) (Day) (Year)

7. AGE 58 Yrs. 8 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: Chris John Gilling

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Barbara Rough

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Lena Rich
(Address): Rich Idd

15. Filed Oct 3 1920 M C Martinson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 3 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1919, to Oct 3 1920 that I last saw h[illegible] alive on Oct 3 1920 and that death occured on the date stated above, at 12 — M.

The CAUSE OF DEATH* was as follows: Carcinoma of the Stomach

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M C Martinson M. D.
10/3 1920 (Address) Aberdeen Idd

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Springfield Idd — DATE OF BURIAL: Oct 5 1920

20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31939

Registered No. .....

Registration District No. .....

Primary Registration District No. .....

1. PLACE OF DEATH.

County of Bonner

City of Laclede Ida (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Knapp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. not known (Month) (Day) (Year)

7. AGE: 54 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) not known

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15. Filed Oct 17 1920 H W Bridges Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1920, to Oct 14 1920, that I last saw him alive on Oct 14 1920, and that death occured on the date stated above, at 8:00 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary) .....

(Duration) yrs. mos. ds.

Oct 14 1920 (Signed) H W Bridges M. D.

(Address) Laclede Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....3 days

Where was disease contracted if not at place of death?.....

Former or usual residence Canada

19. PLACE OF BURIAL OR REMOVAL: Laclede Idaho. DATE OF BURIAL: Oct 17 1920

20. UNDERTAKER: B W Pugh ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24858

CERTIFICATE OF DEATH

Registration District No. [illegible]

Primary Registration District No. 21[illegible]

City of Priest River (No. ____ St.) Registered No. 25

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Margurite Burns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 26 (Day) 1885 (Year)

7. AGE: 35 Yrs. --- Mos. 26 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Wm. Ableman

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): n ot known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [illegible] Burns

(Address) Priest River

15. Filed Nov 1 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 18 day of Oct 1920, to Oct 22 1920 19, that I last saw her alive on Oct 22 1920 19, and that death occurred on the date stated above, at 4.20 A. M.

The CAUSE OF DEATH* was as follows:

Pelvic Abcess

(Duration) --- Yrs. --- mos. 8 ds.

Contributory (Secondary) ---

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) C P Geezhoff M. D.

Oct 22 19 20 (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL: Oct [illegible]

20. UNDERTAKER [illegible] | ADDRESS [illegible]

MARGIN RESERVED FOR BINDING — THIS IS A PERMANENT RECORD

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back.

BYRNS-YORK CO., PRINTERS & BINDERS, BOISE, IDAHO

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 83

Primary Registration District No. 2185

File No. 31941

County of Bonner

City of Priest River (No. ..... St.)

Registered No. 24

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin Watson Carpenter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: ~~XXXX~~ White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 14 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 8 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Foo Carpenter

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Arlie Payne

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Carpenter

(Address) Priest River, Idaho

15.

Filed Nov 1 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1920 to Oct 14 1920, that I last saw him alive on Oct 14 1920 19....., and that death occurred on the date stated above, at 11.40 P. M.

The CAUSE OF DEATH* was as follows:

Blue Baby. Non closure of foramen ovale

8 hours

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Gustafson M. D.

Oct 15 1920 (Address) Priest River

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL Oct 16 1920

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-15 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31972.
Registered No. .....

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79
Primary Registration District No. 716
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Roy Howard Moore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ..... 1 ..... (Month) (Day) (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): G. N. Ry

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: William Moore

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ..... Vanse Moore
(Address) ..... Hillyard Wash

15. Filed Oct. 2nd 1920. ..... E E Fry ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... Sept 30 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ....., ...M.
The CAUSE OF DEATH* was as follows:

Crushed in Rail
way wreck

(Duration) ..... Yrs..... mos. ..... ds.

Contributory .....
(Secondary)

(Duration) ..... Yrs..... mos. ..... ds.

(Signed) C. D. Simonds Coroner M.D.
10/2 1920. (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sand Point, Idaho
DATE OF BURIAL ..... 191..

20. UNDERTAKER: McCloskey
ADDRESS: Bonners Ferry, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31943
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 79
Primary Registration District No. 216
(No. ....., ... St.)

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amelia Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 7 (Day) 1855 (Year)

7. AGE: 64 Yrs. 11 Mos. 25 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Christenson Olson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. D. Johnson
(Address) Bonners Ferry Idaho

15. Filed Oct 4th 1920. E E Ing. Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23rd 1920 to Oct 2nd 1920, that I last saw h[illegible] alive on Oct 1st 1920. and that death occurred on the date stated above, at 3 A. M.

The CAUSE OF DEATH* was as follows:
Senile gangrene of leg.
.....
.....
.....(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E E Ing. M. D.
Oct 4 1920. (Address) Bonners Ferry, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonner Ferry Idaho
DATE OF BURIAL: Oct 4 1920

20. UNDERTAKER: [illegible]
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31944
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 79
Primary Registration District No. 315-6

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry Ida
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)

2. FULL NAME Robert Wellington Farter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) (Day) 1862 (Year)

7. AGE: 58 Yrs. 4 Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Locomotive Engineer
(b) General nature of industry, business, or establishment in which employed (or employer): G. N. Ry.

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: George Farter

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Mary Dammarell

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. B. Farley
(Address) Kalispell Mont.

15. Filed Oct. 30 1920 E E Fry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 30 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 30 1920 to Oct. 30 1920
that I last saw him alive on Oct. 30 1920
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Fracture of Skull (base)

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
Oct. 30 1920 (Address) Bonners Ferry, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash
DATE OF BURIAL ..... 191...

20. UNDERTAKER: P. P. Tooley
ADDRESS

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31945
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 29
Primary Registration District No. 2166

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

2. FULL NAME Rufus Audrey Hatchett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 12 (Day) 1884 (Year)

7. AGE: 36 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: B. Lee Hatchett

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mayo Simmons
(Address) Moravia Idaho

15. Filed Oct. 10th 1917. E E Ives Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 9 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1917 to Oct 9 1917
that I last saw h. alive on Oct 9 1917
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Acute Gangrenous Appendicitis
.....
.....
(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Acute Jaundice
(Duration) ..... Yrs. ..... mos. 12 ds.
(Signed) L. T. G. Ames M. D.
19.... (Address) Bonners Ferry Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moravia Idaho — DATE OF BURIAL: Oct 10 1917
20. UNDERTAKER: Stookey — ADDRESS: Bonners Ferry

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31946
Registered No. .....

Registration District No. 29
Primary Registration District No. 2156
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Boundary
City of Bonners Ferry

2. FULL NAME Emera Miles Kinnear

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. July (Month) 7 (Day) 1896 (Year)

7. AGE: 24 Yrs. 3 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Bonners Ferry Idaho

10. NAME OF FATHER: William L. Kinnear

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Jane Repp

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. L. Kinnear
(Address) Bonners Ferry Idaho

15. Filed Oct. 27th 1920. ..... Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 18 1920 to Oct. 27 1920
that I last saw h[illegible] alive on Oct. 26th 1920
and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:
Cerebral tumor (Tuberculer)
.....
(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
Oct 27 1920. (Address) Bonners Ferry Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: 10/29 1920

20. UNDERTAKER: O. B. Cooley — ADDRESS: Bonners Ferry Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31947
Registered No.

1. PLACE OF DEATH

County of Butte

City of Arco

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59

Primary Registration District No. 2129

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Boyle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: November (Month) 30 (Day) 1854 (Year)

7. AGE: 65 Yrs. 10 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kays Ward Utah

10. NAME OF FATHER: Lyman Hockins

11. BIRTHPLACE OF FATHER (State or Country): Germantown N.Y.

12. MAIDEN NAME OF MOTHER: Abbie

13. BIRTHPLACE OF MOTHER (State or Country): Jackson Ville Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Louis Fouts

(Address) Arco Idaho

15. Filed 10/9 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Oct 9 1920 that I last saw her alive on Oct 9 1920 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): Diabetis Mellitus

(Duration) 15 yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

10/9 1920 (Address) Arco Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco Idaho — DATE OF BURIAL: 10/11 1920

20. UNDERTAKER: E. G. Sweet — ADDRESS: Arco Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31948
Registered No.

Registration District No. 7
Primary Registration District No. 2004
(No. ..... St.)

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hardin F. Duval
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
65 June (Month) 25 (Day) 1855 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) W. Virginia

10. NAME OF FATHER Alexander Duval

11. BIRTHPLACE OF FATHER (State or Country) Sea Waters

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country) Maryland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ella H. Duval.
(Address) Nampa R. 2

15.
Filed Nov. 13 1920 Pearl Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
July (Month) 14th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28th 1920 to July 14th 1920 that I last saw h.. alive on July 14th 1920 and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:
Sarcoma of left hip.

..... (Duration) 0 Yrs. 7 mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jno. A. Kelly M. D.
19..... (Address) Nampa Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	6-15-1920
20. UNDERTAKER	ADDRESS
Fred R. Robertson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7

Primary Registration District No. Caldwell 2006 File No. 31949

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

(No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Whipple

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July 7 1863 (Month) (Day) (Year)

7. AGE: 57 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Edson Whipple

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs J A Whipple

(Address) Nyssa Oregon

15.

Filed Nov. 10 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 25 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 18th 1920, to Oct. 25th 1920 that I last saw h[illegible] alive on Oct. 25th 1920 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Perforation of duodenal ulcer.

(Duration) — Yrs. — mos. 8 ds.

Contributory (Secondary) Chronic Duodenal ulcer.

(Duration) 2 yrs. 6 mos. 0 ds.

(Signed) Fred A. McKillop M. D.

19 (Address) Nampa, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerdown Cem. | DATE OF BURIAL: 10/28 1920

20. UNDERTAKER: Fred K. Robinson | ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1002
File No. 31950
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Magee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M

4. COLOR OR RACE W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married

6. DATE OF BIRTH Sept (Month) 15 (Day) 84 (Year)

7. AGE 86 Yrs. — Mos. — ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Robert Magee

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Nancy Lockhart

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Dora Poole

(Address) Nampa Ida

15.

Filed NOV. 10 1920 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1920, to Oct 25 1920, that I last saw h[im] alive on Oct 25 1920, and that death occurred on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Mitral insufficiency

(Duration) 5 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) H. P. Roes M. D.

Oct 26 1920 (Address) Nampa, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rosedale Cem | **DATE OF BURIAL** 10/28 1920

20. UNDERTAKER J K Robinson | **ADDRESS** Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31951
Registered No.

Registration District No. 7
Primary Registration District No. 225

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ulric La Lande
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) 1 (Day) ..... (Year)

7. AGE: 43 Yrs. 9 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cleaner & Dyer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Maurice La Lande

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Cherrier

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. La Lande
(Address): Nampa Ida

15.
Filed NOV. 10 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 27, 1920, to Oct. 26, 1920 that I last saw h. in alive on Oct. 26, 1920 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Pyaemia with multiple joint infection

(Duration) 0 Yrs. 2½ mos. ..... ds.
Contributory (Secondary): Angina - Carbuncle
(Duration) 0 yrs. 0 mos. 14 ds.

(Signed) Leo A. A. Kellogg M. D.
19..... (Address) Nampa, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Catholic Cem. DATE OF BURIAL: 10/29 1920

20. UNDERTAKER: H. Robinson ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31952
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa R.F.D.# (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1004

2. FULL NAME Edmiston Fred

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: April (Month) 30 (Day) 1875 (Year)

7. AGE: 45 Yrs. 5 Mos. 14 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Wm H. Edmiston

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Anna McCaw

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Fred Edmiston
(Address) Nampa R.F.D. # 2.

15. Filed Nov. 10 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1920, to ..... 19..... that I last saw him alive on Oct 13 1920 and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Accidental smothering from a cave-in of root-cellar at barn.
Instant
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. R. Proctor M. D.
10/17/1920 (Address) Nampa, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	10/19 1920
20. UNDERTAKER	ADDRESS
Fred K. Robertson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31954
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa R 5
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 2006
(No. ..... Child St.)

2. FULL NAME Mrs R. Olson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: July (Month) 27 (Day) 1822 (Year)

7. AGE: 98 Yrs. 2 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Olof. Bobilden

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ingvald Olson
(Address) Nampa R. 7 B. 5

15. Filed Nov. 9 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1918, to Oct 24 1920
that I last saw her alive on Oct 24 1920
and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:
Senile Paralysis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Murray M. D.
10/27/1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Riverlawn Cem — DATE OF BURIAL: 10/27 1920

20. UNDERTAKER: Fred T. Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Murray

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. ..... St.)

File No. 31955

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Howard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	Married

6. DATE OF BIRTH — 1 (Month) (Day) (Year)

7. AGE — 26 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) N. M.

10. NAME OF FATHER Carus

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E. J. Howard

(Address) Nampa Ida

15. Filed Oct 28 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 8 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1920 to Oct 8 1920 that I last saw her alive on Oct 7 1920 and that death occurred on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes

(Duration) two Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. B. Smith M. D.

10/11 1920 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kohlulawn Cem	Oct 10 1920
20. UNDERTAKER	**ADDRESS**
Fred T. Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31956

Registered No.

1. PLACE OF DEATH

County of

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sauro M. Sierro

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: ..... 1..... (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country):

10. NAME OF FATHER: Mexican.

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed Oct 28 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 22 1920 to June 28 1920 that I last saw him alive on June 27 1920 and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows: Fracture cervical spine. Accidental.

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. B. Smith M. D.

6/30 1920 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 6 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? On R. R. Section

Former or usual residence Mexico.

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 6-29 1920

20. UNDERTAKER: Robinson — ADDRESS: Nampa

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 31957
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred T. Yamasaki

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male
4. COLOR OR RACE Jap
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
6. DATE OF BIRTH ..... 1 ..... (Month) (Day) (Year)
7. AGE 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work Beet Grower
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country) Japan
10. NAME OF FATHER
11. BIRTHPLACE OF FATHER (State or Country)
12. MAIDEN NAME OF MOTHER
13. BIRTHPLACE OF MOTHER (State or Country)
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Yoji Yamaguchi
(Address) 267-124 ch St
15. Filed Oct 28 1920 Ogden Utah
Earle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 12 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:
Suicide:- Shot himself in neck with twelve gauge shot gun.
..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. V. Beckham Coroner M. D.
19..... (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ogden Utah — DATE OF BURIAL: ..... 19.....
20. UNDERTAKER: Fred R. Robinson — ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 31958

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amede Hullebusch
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 12 (Day) 1908 (Year)

7. AGE: 12 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In school
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Belgium

10. NAME OF FATHER: C Hullebusch

11. BIRTHPLACE OF FATHER (State or Country): Belgium

12. MAIDEN NAME OF MOTHER: Eliza Mars

13. BIRTHPLACE OF MOTHER (State or Country): Belgium

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C Hullebusch
(Address) Nampa Ida

15. Filed Nov. 9 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9, 1920, to Oct 28, 1920 that I last saw h[illegible] alive on Oct 27, 1920 and that death occurred on the date stated above, at 4a, M.
The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) ..... Yrs. ..... mos. 19 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Leo W Chilton M. D.
19..... (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Catholic Cem — DATE OF BURIAL: 10/29/1920

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM U. S. No. 6-A-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon — Registration District No. 7 — Primary Registration District No. 1120 — File No. 31959

City of Nampa (No. ..... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Young

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: July (Month) 6 (Day) 1830 (Year)

7. AGE: 90 Yrs. ..... Mos. ..... ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Do not Know

11. BIRTHPLACE OF FATHER (State or Country): " " "

12. MAIDEN NAME OF MOTHER: " " "

13. BIRTHPLACE OF MOTHER (State or Country): " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Margaret Young
(Address) Nampa Ida

15. Filed Nov 9 1920 — Pearle Dodds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Senility
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration) .....yrs.....mos.....ds.
(Signed) Thos E. Mangum M. D.
Oct 28 1920 (Address) City Phys Nampa

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	10/31 1920

20. UNDERTAKER	ADDRESS
J R Robertson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
(No. ..... St.)

File No. 31960
Registered No. .....

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl Thomas
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1893 (Year)

7. AGE: 27 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: J. J. Pickens

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Bragg

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. P. Thomas
(Address) Nampa Idaho

15. Filed Nov. 9 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1920, to Oct 27 1920
that I last saw h.er alive on Oct 27 1920
and that death occurred on the date stated above, at 5 A M.
The CAUSE OF DEATH* was as follows:
Injured by fall on cement walk
.....(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) —
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. P. Murray M. D.
10/30 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Crescent Okla	19 .....

20. UNDERTAKER	ADDRESS
Fred K. Robinson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31961
Registered No. .....

1. PLACE OF DEATH.
County of Canyon
City of Nampa
(No. Mercy Hospital St.)
Registration District No. 7
Primary Registration District No. 1056
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donald Moffatt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept (Month) 16 (Day) 1907 (Year)

7. AGE: 12 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In school
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebr.

10. NAME OF FATHER: Dow Moffatt

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Ruth Lemon

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G. A. Moffatt
(Address) .....

15.
Filed Nov. 10 1920. Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May, 18, 1920, to May, 21, 1920, that I last saw h[illegible] alive on May, 21, 1920, and that death occured on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:
Streptococcic sore throat complicated by sinusitis (Frontal) and Cerebral abcess.
(Duration) 0 Yrs. 0 mos. 4 ds.
Contributory (Secondary) Died immediately following excision of cerebral abcess
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Geo. A. Tellogg M. D.
19..... (Address) Nampa, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 5-22 1920

20. UNDERTAKER: Fred K. Robinson ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 1005

(No. ..... St.)

File No. 31962

Registered No. 134

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marie Shizuko Koyama

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Jap.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 12 (Month) 25 (Day) 1918 (Year)

7. AGE: 1 Yrs. 10 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Sachishi Koyama

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Oka Sasan

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S. Koyama

(Address) Caldwell Idaho.

15. Filed Nov 1st 1920 John S. Ineyes Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26. 1920 to Oct 31 1920 that I last saw her alive on Oct 31 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. Ailey M. D.

11-1 1920 (Address) Caldwell Ida.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: 11-2- 1920

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 31963
Registered No. 733

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Caldwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 7 (Month) 5 (Day) 1848 (Year)

7. AGE: 72 Yrs. 3 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Abner Caldwell

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Lida Mankins

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Caldwell
(Address) Caldwell Idaho.

15. Filed Oct. 29 1920 John S. Meyers
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 27, 1920 19..., that I last saw her alive on Oct. 27 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
accompanied by secondary involvement
throughout the body. Dilitation of heart.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr. Robert F. Haden M.D.
Oct. 29 1920 (Address) Caldwell, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: [illegible]
DATE OF BURIAL: 10-29 1920

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ..... St.)

File No. 31964
Registered No. 132

1. PLACE OF DEATH

County of Canyon
City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Augusta Naberai

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	widow

6. DATE OF BIRTH: Sept. (Month) 9 (Day) 1846 (Year)

7. AGE: 74 Yrs. / Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Pudelka

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Olga Lyoning
(Address)

15. Filed Oct. 28- 1920 John L. Meyer. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct '20 1920, to Oct 28 1920, that I last saw h. alive on Oct 25 1920, and that death occurred on the date stated above, at 4:10 A.M.
The CAUSE OF DEATH* was as follows:
Heart failure
(Postmortem)

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) old age (74)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. O. Dudley M. D.
Oct 28 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Green Buck, Minn.	19 .....

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 31965
Registered No. 131

1. PLACE OF DEATH
County of Canyon
City of Caldwell (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Billy Enes

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: w hite
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Dec (Month) 18 (Day) 1919 (Year)

7. AGE: Yrs. 10 Mos. 7 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Preston Enes

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Dene Sorenson

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Preston Enes
(Address) Caldwell Idaho

15. Filed Oct. 26 1920 John S. Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1920 to Oct. 24 1920
that I last saw him alive on Oct 24 1920
and that death occurred on the date stated above, at 4 a M.
The CAUSE OF DEATH* was as follows:
Septic enteritis & Exhaustion
(Duration) ..... Yrs. ..... mos. 21 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. Kadey M. D.
10-25 1920 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	Oct 26 1920
20. UNDERTAKER	**ADDRESS**
C. L. Peckham	Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

H4

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Caldwell (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 1005

File No. 31566

Registered No. 130

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs M. C. Lively

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: 12 (Month) 24 (Day) 1 (Year)

7. AGE: 69 Yrs. 9 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Tennessee

10. NAME OF FATHER Wm B. Mansell

11. BIRTHPLACE OF FATHER (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Mary

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. T. Lively

(Address) 8 th Kentucky Caldwell

15. Filed Oct. 23 - 1920 John V. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1, 18 1920 to Oct 22nd 1920 that I last saw h.. alive on Oct 22nd 1920 and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

..... (Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Disease of Heart

..... (Duration) 3 yrs. ..... mos. ..... ds.

(Signed) J. M. Henry M. D.

19 ..... (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 10-24-1920

20. UNDERTAKER CASE FURNITURE CO. | ADDRESS Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 31967
Registered No. 729

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. County Farm — St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anderson A Howard
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE:
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: 7 (Month) 24 (Day) 1835 (Year)

7. AGE: 85 Yrs. 2 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Elisha Howard

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Barbara Conley

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Sam Johnson
(Address): Nampa

15. Filed OCT-20-1920 John L Meyers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1920, to Oct 19 1920, that I last saw h.m alive on Oct 19 1920, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Paralysis —

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Arterial Sclerosis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. D. Forney — M. D.
10/20 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 10-20 1920

20. UNDERTAKER: CASE FURNITURE CO
ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2005
File No. 31568
Registered No. 128

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Simon Shepard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: March 2 (Month) (Day) 1891 (Year)

7. AGE: 29 Yrs. 7 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Well driller
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: John B. Shepard

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Martha E. Workman

13. BIRTHPLACE OF MOTHER (State or Country): North Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Shepard
(Address) Weiser, Ida.

15. Filed Oct. 20 1920 John L. Imes
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1920 to Oct 19 1920 that I last saw h.. alive on Oct 19 1920 and that death occurred on the date stated above, at 11:45 M.

The CAUSE OF DEATH* was as follows: Peritonitis, (Ruptured Appendix)

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Coe M. D.

10/20 1920 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ontario Ore
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: C. V. Peckham
ADDRESS: Caldwell, Ida

FORM V. S. No. 5-45 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 31969
Registered No. 127

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza A Elliott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: March (Month) 7 (Day) 1839 (Year)

7. AGE: 81 Yrs. 7 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER J M Rutledge

11. BIRTHPLACE OF FATHER (State or Country) Georgia

12. MAIDEN NAME OF MOTHER Richardson

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lillian E Flames
(Address) Caldwell RR 5

15.
Filed Oct 18 1920
John L Meyer
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 6 1920, to Oct 9 1920, that I last saw her alive on Oct 9 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. F. Hunt M.D.
19..... (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 10-20-1920

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2004
(No. ..... , ... St.)

File No. 31970
Registered No. 126

1. PLACE OF DEATH
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Alfred Prall
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 ..... (Year)

7. AGE: ..... Yrs. 8 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chas Prall

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Alda Smith

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Prall
(Address) R.1. Nampa Ida

15. Filed Oct. 15 1920 John L. Preston
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1920 to Oct 14 1920 that I last saw him alive on Oct 14 1920 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Malnutrition and
Mitral insufficiency
(Duration) Yrs. 8 mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Guy M.D. M. D.
10/15 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: Oct 16 1920

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
(No. ..... St.)

File No. 31971
Registered No. 125

1. **PLACE OF DEATH**

County of Canyon
City of Caldwell Ida

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Roy Phillip Shaw

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
male	white	single

6. **DATE OF BIRTH** June (Month) 21 (Day) 1904 (Year)

7. **AGE** 16 Yrs. 3 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work. At home
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Missouri

10. **NAME OF FATHER** Edward S. Shaw

11. **BIRTHPLACE OF FATHER** (State or Country) Illinois

12. **MAIDEN NAME OF MOTHER** Blanch Stiffler

13. **BIRTHPLACE OF MOTHER** (State or Country) Iowa

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Edward S. Shaw
(Address) Caldwell Ida Ro

15. Filed Oct. 11 1920 John S. Mayes Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Oct (Month) 10 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Sept 15 1920 to Oct 10 1920
that I last saw him alive on Oct 9 1920
and that death occurred on the date stated above, at 4:30 A.M.
The CAUSE OF DEATH* was as follows:

Appendicitis (ruptured)
Septic Peritonitis

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Adhesions & obstruction of bowel
(Duration) ..... yrs. ..... mos. 13 ds.

(Signed) C M Haley M. D.
10/11 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ontario Ore	10-12 1920

20. **UNDERTAKER** V. Peckham ADDRESS Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31972

Registered No. 45

1. PLACE OF DEATH

County of Kootenai

City of Rosfino

(No. Parky St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 60

Primary Registration District No. 216

2. FULL NAME Ruth Arnold

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: March 11, 1918 (Month) (Day) (Year)

7. AGE: 2 Yrs. 6 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Edgar Arnold

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Emmeretta Evans

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Tansley
(Address) Rosfino Ida

15. Filed Oct 8 1920 J. M. Tansley Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 7 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1920 to Oct 7 1920 that I last saw h[illegible] alive on Oct 7 1920, and that death occurred on the date stated above, at 11:15 P.M.
The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) -

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Tansley M. D.

Oct 8 1920 (Address) Rosfino Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rosfino Ida | DATE OF BURIAL: Oct 8 1920

20. UNDERTAKER: C. E. Dobbs & Son | ADDRESS: Rosfino Ida

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2168
(No. ....., ... St.)

File No. 31973
Registered No. 46
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Meisner

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: About (Month) (Day) 1871 (Year)

7. AGE: 49 yrs. ✓ mos. ✓ ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): Housework

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho

15. Filed Oct 20 1920 J. H. Finley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 18th (Day) 1920, (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 4th 1920, to October 18 1920, that I last saw her alive on October 18 1920 and that death occurred on the date stated above, at 9:25 P.M. Evening

The CAUSE OF DEATH* was as follows:
Acute Mania

(Duration) 3 yrs. mos. ds.
Contributory (Secondary) Insanity
(Duration) ? yrs. 4 mos. ds.

(Signed) John C. Givens M. D.
Oct. 19 1920. (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. — mos. 14 days. In the State about 17 years ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence Kamiah, Idaho

19. PLACE OF BURIAL OR REMOVAL: Kamiah Idaho
DATE OF BURIAL: ..... 191...

20. UNDERTAKER: C. J. Connor
ADDRESS: Kamiah Ida

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31974

Registered No. 47

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Clearwater

City of Orofino (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90

Primary Registration District No. 2168

2. FULL NAME Eugene M. Clithorpe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: March 7 1848 (Month) (Day) (Year)

7. AGE: 72 yrs. 6 mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brick Layer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Atteberry
(Address) Orofino, Idaho

15. Filed Sept 25 1920 J. M. Davis, Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 24 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 11- 1920, to Sept 24 1920, that I last saw him alive on Sept 24 1920 and that death occurred on the date stated above, at 6 45 M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Girvin M. D.

9/24 1920 (Address) Per J. M. Davis Deputy Orofino Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death X yrs. 8 mos. 13 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? I do not know

Former or usual residence Potlatch, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Palouse Wash. DATE OF BURIAL: Sept 26 1920

20. UNDERTAKER: E. E. Bobo and Son ADDRESS: Orofino Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WHITE PRINTED, WITH CONTRASTING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
(No. ..... St.)

File No. 31975
Registered No. 48

1. PLACE OF DEATH
County of Canyon
City of Greer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Jefferson Root

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 20 (Day) 1830 (Year)

7. AGE: 90 Yrs. 4 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio Cashtabula Co

10. NAME OF FATHER: — Root

11. BIRTHPLACE OF FATHER (State or Country): — —

12. MAIDEN NAME OF MOTHER: — — —

13. BIRTHPLACE OF MOTHER (State or Country): — — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs T J Root
(Address) Greer Ida

15. Filed Oct 5 1920 J M Tandy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Brights Disease

(Duration) ? Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ? yrs. ..... mos. ..... ds.

(Signed) J. M. Tandy M. D.
Oct 4 1920 (Address) Drake Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Clarkston Wash	10/7 1920
20. UNDERTAKER	ADDRESS
A C Merchant	Clarkston Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No. 2203
File No. 31976
Registered No.

1. PLACE OF DEATH.
County of Clark
City of Dubois (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rose Dora Jenkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Baby

6. DATE OF BIRTH: 6 (Month) 24 (Day) 1920 (Year)

7. AGE: ..... yrs. 3 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Carmen, Idaho

10. NAME OF FATHER: Chas. E. Jenkins

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Laura Robbins

13. BIRTHPLACE OF MOTHER (State or Country): Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Robbins Grandmother
(Address) Carmen, Idaho

15. Filed Oct 15 1920 C E Jones M D Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10/10 1920, to Oct 11th & 12 1920, that I last saw her alive on 10/12 1920 and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Dysentery - Sick five days before I saw Pt.

..... (Duration) ..... yrs. ..... mos. 8 ds.
Contributory (Secondary) Bottle baby Mother died

..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A Howard Young M.D.
10/13 1920 (Address) Dubois, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? Carmen
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Humphrey Ida. DATE OF BURIAL: 10/14 1920

20. UNDERTAKER: Kane ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 58th

Primary Registration District No. 2138

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31977

Registered No.

1. **PLACE OF DEATH**

County of Camas

City of Coral (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Ernest Eugene Hobdey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: male

4. **COLOR OR RACE**: white

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): single

6. **DATE OF BIRTH**: Oct. (Month) 1 (Day) 1920 (Year)

7. **AGE**: Yrs. Mos. 3 ds.

IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country): Camas Co., Idaho.

10. **NAME OF FATHER**: Joe M. Hobdey

11. **BIRTHPLACE OF FATHER** (State or Country): Wisconsin

12. **MAIDEN NAME OF MOTHER**: Mary L. Fletcher

13. **BIRTHPLACE OF MOTHER** (State or Country): Texas

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Joe M. Hobdey

(Address) Coral, Idaho

15. Filed Oct 25 1920 L Willencheck Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Oct (Month) 4 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Oct 1 1920, to Oct 1st 1920 that I last saw h[im] alive on Oct 1st 1920 and that death occurred on the date stated above, at 2:30 A. M.

The CAUSE OF DEATH* was as follows:

Cause of Death Unknown

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) L Willencheck M. D.

Oct 25 1920 (Address) Fairfield, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Coral, Idaho — **DATE OF BURIAL**: Oct 6 1920

20. **UNDERTAKER** — **ADDRESS**

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58th
Primary Registration District No. 2138
File No. 31979
Registered No.

1. PLACE OF DEATH
County of Camas
City of Corral
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward H Jones
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: June (Month) 4th (Day) 1918 (Year)

7. AGE: 2 Yrs. 4 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Camas Co, Idaho.

10. NAME OF FATHER: Harvey B Jones

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Daisy Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harvey B Jones
(Address) Condi, Idaho

15. Filed Nov 9th 1920 — I Wilencheck, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 14th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 14 1920 to October 14 1920 that I last saw h[im] alive on October 14 1920 and that death occurred on the date stated above, at 8:00 P.M.

The CAUSE OF DEATH* was as follows:

Convulsions following acute enteritis

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) I Wilencheck M. D.

Oct 25 1920 (Address) Fairfield, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every statement of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms that may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2155
File No. 31980
Registered No.

1. PLACE OF DEATH
County of Custer
City of Mackay
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wiley Jones
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 22 (Day) 1842 (Year)

7. AGE: 78 Yrs. 3 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Jones

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Katherine Fogelsong

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Wiley Jones
(Address) Mackay Idaho

15. Filed Oct. 22 1920 Rose Nowack Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1917, to Oct. 1920, that I last saw him alive on Oct 15 1920 and that death occurred on the date stated above, at 6 A.M.
The CAUSE OF DEATH* was as follows:

Senile paresis

(Duration) 17 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. H. Jones M. D.
Oct 22 1920 (Address) Mackay Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt. McCoy | DATE OF BURIAL ..... 19.....

20. UNDERTAKER Carpenter & Baxter | ADDRESS Mackay Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. Regena
Primary Registration District No. Regena Precinct
File No. 31981
Registered No.

1. PLACE OF DEATH

County of Elmore
City of Regena
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cleo Louise Little

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: girl

4. COLOR OR RACE: W

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~: Single (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 30 (Day) 1920 (Year)

7. AGE: Yrs. 8 Mos. 9 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: J. M. Little.

11. BIRTHPLACE OF FATHER (State or Country): Arkansas.

12. MAIDEN NAME OF MOTHER: Cleo Duvall.

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. M. Little.

(Address) Regena, Idaho.

15.

Filed 19

J P Boyle
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1920 to Oct 8th 1920, that I last saw h[illegible] alive on Oct 8th 1920, and that death occurred on the date stated above, at 5 A.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jos. R. Nunnelly M. D.

19 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mayfield Cemetery — DATE OF BURIAL: 10/10 1920

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

31982

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Oneida

City of Preston

(No. 60 W. 2nd North St.)

Registration District No. 27

Primary Registration District No. 219

File No. [redacted]

Registered No. 70

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Lee Christenson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 13 (Day) 1919 (Year)

7. AGE: Yrs. 10 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ——

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Richmond, Utah.

10. NAME OF FATHER: J. W. Christenson

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Florence Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Christenson

(Address) Preston Idaho.

15. Filed 8/1/20 1920 Dora Dowdle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920 to Aug 1 1920, that I last saw h. l. alive on Aug 1 1920, and that death occurred on the date stated above, at 11 a M.

The CAUSE OF DEATH* was as follows:

acute enteritis

Bottle fed baby

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Curtis Bland M. D.

8/1/1920 (Address) Preston, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Richmond Utah. DATE OF BURIAL: Aug 2 1920

20. UNDERTAKER: G. A. Sandquist ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 3158

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert W. Logan

Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: 4 (Month) 4 (Day) 1886 (Year)

7. AGE: 34 Yrs. 5 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer & miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Robt L Logan

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sarah Ware

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robt Logan
(Address) St Anthony Ida

15. Filed Oct 10 1920 W. Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26, 1920, to Sept 28 1920, that I last saw him alive on 9/28 1920 and that death occurred on the date stated above, at 12 30 M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Auto intoxication

(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) Jno R Gray M. D.
10/1 1920 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sutton — DATE OF BURIAL: 10/3 1920

20. UNDERTAKER: Taylor — ADDRESS: St Anthony Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 94
Primary Registration District No. 3122
File No. 31985

1. PLACE OF DEATH
County of Fremont
City of Teton (No. ..... St.)
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Bean Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 2nd (Day) 1920 (Year)

7. AGE: ... Yrs. ... Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: David M Davis

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Margret Bean

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David M Davis
(Address) Teton, Ida.

15. Filed Oct 10 1920 [illegible]
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/6/1920 to 9/27/1920 that I last saw him alive on 9/27/1920, and that death occurred on the date stated above, at 2 30 M.

The CAUSE OF DEATH* was as follows:

Spinal meningitis

(Duration) ... Yrs. ... mos. 3 ds.

Contributory (Secondary) Indigestion

(Duration) ... yrs. ... mos. 11 ds.

(Signed) Ivor R Young M. D.

9/28 1920 (Address) Onyo St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Teton, Ida.	Sept 28 1920
20. UNDERTAKER	ADDRESS
David R Young	Teton, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99

Primary Registration District No. 2(17)

File No. 31986

Registered No.

1. PLACE OF DEATH

County of Fremont.

City of St. Anthony.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera Leatham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	

6. DATE OF BIRTH: Aug (Month) 13 (Day) 1918 (Year)

7. AGE: 2 Yrs. 1 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) St Anthony, Idaho.

10. NAME OF FATHER L. B. Leatham.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Ice Rose

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ivy Leatham

(Address) St Anthony Ida.

15. Filed Oct 10 1920 W Dwest Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 12th (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 6th 1920 to Sept 12 1920 that I last saw her alive on Sept 12 1920 and that death occurred on the date stated above, at 12:15 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum.

(Duration) ..... Yrs. ..... mos. 6 d. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Frank Watkins M. D.

Sept 13 1920 (Address) St Anthony Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 19.....
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31987

Registered No.

1. PLACE OF DEATH

County of Fremont

City of St anthony (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 2

2. FULL NAME Louis Edmund Barnett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: 9 (Month) 8 (Day) 1900 (Year)

7. AGE: — Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Hugh Barnett

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Lena Moore

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hugh Barnett

(Address) St anthony

15. Filed Oct 10 1920 W Davey Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 8 (Day) 1900 (Year)

17. I HEREBY CERTIFY, That I attended deceased from none 19..., to 9/8 1900 that I last saw h[illegible] alive on 9/8 1900 and that death occurred on the date stated above, at 1.09 M.

The CAUSE OF DEATH* was as follows:

Premature

(Duration) ..... Yrs. ..... mos. 1 hrs ds.

Contributory (Secondary) none

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dr W C Gray M. D.

9/8 1900 (Address) St anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2 1 0
File No. 31988
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Teton
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph T. Jones
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 27 (Day) 1851 (Year)

7. AGE: 69 Yrs. 7 Mos. 12 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: Joseph Jones

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Perry

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Bullin
(Address) Teton Ida

15. Filed Oct 10 1920 [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1920, to Sept 8 1920 that I last saw him alive on 9/2/1920, and that death occurred on the date stated above, at 8 45a M.
The CAUSE OF DEATH* was as follows:
Profacy (anasarca)

(Duration) 1 Yrs. 9 mos. 8 ds.
Contributory (Secondary) Mitral Regurgitation
(Duration) 1 yrs. 8 mos. 8 ds.

(Signed) J. W. R. Gray M. D.
9/8 1920 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Teton
DATE OF BURIAL: 9/10/1920

20. UNDERTAKER: J R Young
ADDRESS: Rexburg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 112
Primary Registration District No. 6
File No. 2-31989
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Marysville
(No.) ..... (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anne Barbara Wohlen.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Dec. (Month) 27 (Day) 1836 (Year)

7. AGE: 83 Yrs. 10 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Switzerland Eggiwill Bern

10. NAME OF FATHER: Geo. Wohlen.

11. BIRTHPLACE OF FATHER (State or Country): Switzerland Eggiwill Bern

12. MAIDEN NAME OF MOTHER: Rent Lenz.

13. BIRTHPLACE OF MOTHER (State or Country): Germ Lenz.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John H. Henderson
(Address) Marysville, Ida.

15. Filed 11-4-1920 A. Merriken
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Heart Lenz

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) General Debility
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Henderson M. D.
Resident
11-4 1920 (Address) Marysville, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg Idaho
DATE OF BURIAL ..... 19.....

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 12
Primary Registration District No. 6
File No. 31990
Registered No.

1. PLACE OF DEATH
County of Fremont
City of Squirrel (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Luetzen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 26 (Day) 1869 (Year)

7. AGE: 51 Yrs. 22 Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farming

9. BIRTHPLACE (State or Country): Concordia Mo.

10. NAME OF FATHER: Dick Luetzen

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Annetta Ecing

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lamar Long
(Address) Squirrel Ida.

15. Filed 9/21/ 1920 C. C. Measham. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) – 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-9- 1920 to 9-18 1920.
that I last saw h— alive on 9-18- 1920
and that death occurred on the date stated above, at H. M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. 10 ds.
Contributory (Secondary) Dont know.
(Duration) yrs. mos. ds.

(Signed) C. C. Measham M. D.
9/21 1920. (Address) Ashton, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Squirrel Cemetery | DATE OF BURIAL 19

20. UNDERTAKER: [illegible] | ADDRESS Driggs Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31991

Registered No.

1. PLACE OF DEATH

County of 2½ miles N of Ada

City of

(No. , St.)

Registration District No.

Primary Registration District No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christena Boyd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: December 1 (Month) (Day) (Year)

7. AGE: eighty four Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: non

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill Ill

10. NAME OF FATHER: Hiram Wallbridge

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Margret. Barker

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): Louis J. Matthews

(Address): Ada Ida

15. Filed Nov 4 1920

J. L. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 20-Twenty/ 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19..., to 19..., that I last saw h... alive on 19..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:

Old age

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. M. Brown - Co. Coroner

10/21 1920 (Address) Montour Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 10 yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death? Old age

Former or usual residence Boise Ida

19. PLACE OF BURIAL OR REMOVAL: Ada Oct

DATE OF BURIAL: 22 1920

20. UNDERTAKER

ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 31992

Registered No.

Registration District No. 6

Primary Registration District No.

1. PLACE OF DEATH

County of Gem

City of Emmett (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Howard Buzzard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: boy

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: September 23 1917 (Month) (Day) (Year)

7. AGE: 3 Yrs. Mos. 17 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jesse D Buzzard

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: May Elledge

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jesse D Buzzard

(Address) Emmett Idaho

15. Filed 10/15 1921

J. A. Reynolds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 10 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1921, to Oct 10 1921, that I last saw h— alive on Oct 9 1921, and that death occurred on the date stated above, at 8-30 A.M.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. A. Reynolds M. D.

10/11 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida — DATE OF BURIAL: 10/11 1921

20. UNDERTAKER: C L Buckmun — ADDRESS: Emmett Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 6
File No. 31994
Registered No. ____

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Violet Louise Perkins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fem
4. COLOR OR RACE: whr
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: May (Month) 25 (Day) 1907 (Year)

7. AGE: 13 Yrs. 5 Mos. — ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: student
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: B. B. Perkins

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Effie L. Griffith ~~Harriet Corbett~~

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B B Perkins
(Address) Ola Idaho

15. Filed Oct 26 1920 — J. L. Reynolds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920 to Oct 25 1920 that I last saw her alive on Oct 25 1920, and that death occurred on the date stated above, at 3 A. M.
The CAUSE OF DEATH* was as follows:
Result of Burns accidentally acquired
(Duration) ____ Yrs. ____ mos. 10 ds.
Contributory (Secondary): Acute Nephritis
(Duration) ____ yrs. ____ mos. 7 ds.
(Signed) Austin G. Boyd M. D.
Oct 25 1920 (Address) Emmett, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Ola Idaho — DATE OF BURIAL: 10/27 1920

20. UNDERTAKER: C. L. Buckmeier — ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

31995

CERTIFICATE OF D[illegible]

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 07

Primary Registration District No. 2119

File No. 31995

Registered No. 71

1. PLACE OF DEATH

County of Franklin

City of Preston (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Byron G. Bickmore

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 13 (Day) 1918 (Year)

7. AGE: 2 Yrs. 6 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logan Utah

10. NAME OF FATHER: William O. Bickmore

11. BIRTHPLACE OF FATHER (State or Country): Paradise Ut.

12. MAIDEN NAME OF MOTHER: Otilla Gasaman

13. BIRTHPLACE OF MOTHER (State or Country): Weston Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Gasaman

(Address) Weston Ida.

15. Filed Nov. 1 19 20. Wm R Curtis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920 to Oct 26 1920, that I last saw h[illegible] alive on Oct 26 1920, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

capilary Branchitis

(Duration) ..... Yrs. ..... mos. One ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Thos B Holder M. D.

19..... (Address) Weston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weston — DATE OF BURIAL: Oct. 31 1920

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3195

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. ..... St.)

2. FULL NAME Lydia Ann Russell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	widow

6. DATE OF BIRTH: Jan (Month) 1st (Day) 1838 (Year)

7. AGE: 82 Yrs. 9 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Jesse Hobson

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. C. Russell
(Address) Gross, Idaho

15. Filed Nov 1 1920 J. L. Heyposd
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 18 1920, to Oct. 24 1920, that I last saw h.. alive on October 18 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Brights Disease acute

(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Senility
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Schmitz M. D.
10-28-1920 (Address) Midvale Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	10/26 1920

20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. # 24
Primary Registration District No.
File No. 31997
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Gooding
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jacob Meyer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Nov. (Month) 20 (Day) 1846 (Year)

7. AGE: 73 Yrs. 10 Mos. 28 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming (Retired)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Brucew Germany

10. NAME OF FATHER: — Meyer

11. BIRTHPLACE OF FATHER (State or Country): — Germany

12. MAIDEN NAME OF MOTHER: Dorothea Record

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Meyer
(Address) Gooding Idaho

15. Filed 10-19 1920 F Hoag
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 1st 1919, to Oct. 18th 1920, that I last saw h[illegible] alive on Oct. 18th 1920, and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Cystitis

(Duration) 15 Yrs. mos. ds.
Contributory (Secondary) Acute nephritis
(Duration) yrs. mos. 5 ds.

(Signed) J. H. Cromwell M. D.
10/18 1920 (Address) Gooding Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gooding Cemetary	Oct 20 1920
20. UNDERTAKER: A E Thompson	ADDRESS: Gooding

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 31998
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Hagerman
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 21
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Eugene B Gard

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): married
6. DATE OF BIRTH: Apr (Month) 13 (Day) 1868 (Year)
7. AGE: 57 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Harness & shoe maker
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Penn
10. NAME OF FATHER: Ezra B Gard
11. BIRTHPLACE OF FATHER (State or Country): Penn
12. MAIDEN NAME OF MOTHER: Adelia Newcomb
13. BIRTHPLACE OF MOTHER (State or Country): Penn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B. W. Harmsworth
(Address) Bliss Ida
15.
Filed Sept 19 1920 T. R. V. Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sept 19 1920, to 19, that I last saw him alive on Sept 19 1920, and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) 3 or 4 hours
Contributory (Secondary) Nephritis
(Duration) yrs. mos. ds.
(Signed) T. R. V. Greene M. D.
Sept 19 1920 (Address) Hagerman Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Burley
DATE OF BURIAL 19
20. UNDERTAKER: Jones
ADDRESS Buhl Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 21

File No. 32000

County of

Primary Registration District No.

City of

(No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Iva Garner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: July 27 (Month) (Day) 1920 (Year)

7. AGE: few hours — Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter V Garner

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Minnie L Manaker

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R N Greene

(Address) Nagerman

15. Filed Aug 1 1920 R N Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 23 1920 to June 24 1920 that I last saw h. alive on June 23 1920, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows: June 24-20

Premature birth

(Duration) Yrs. mos. ds.

Contributory (Secondary): measles

(Duration) few hours mos. ds.

(Signed) R N Greene M. D.

July 28 1920 (Address) Nagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: DATE OF BURIAL: July 24 1920

20. UNDERTAKER: Long ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
(No. ..... , ... St.)

File No. 32001
Registered No. 33

County of Idaho
City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucile Mildred Lee

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: June (Month) 6 (Day) 1920 (Year)

7. AGE: Yrs. 9 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Leslie Lee

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mary Sloan

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Leslie Lee
(Address) Grangeville

15. Filed Nov 8 1920 G S Stockton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1920 to ..... 19.....
that I last saw her alive on Oct 9 1920,
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Uremic Colitis

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) Malnutrition

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) B Chapman M. D.
Oct 19 1920 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View — DATE OF BURIAL: Oct 18 1920

20. UNDERTAKER: A J Mangg — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2181
File No. 32002
Registered No. 32

1. PLACE OF DEATH
County of Ida
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John W Long
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1871 (Year)

7. AGE: 39 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: John Long

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Mary Allen

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J W Long
(Address) Grangeville

15. Filed Nov 8 1920 G S Stockton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ——— 19..., to ——— 19...,
that I last saw h... alive on ——— 19...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Fell dead on dance floor

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.
10/16 1920 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairview
DATE OF BURIAL: Oct 17 1920

20. UNDERTAKER: J Mauzy
ADDRESS: City

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 2151
File No. 32003
Registered No. 31

1. PLACE OF DEATH
County of Idaho
City of Grangeville (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cynthia A Gumwalt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Married

6. DATE OF BIRTH: Oct (Month) 2 (Day) 1862 (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds. 4
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Eli Rose

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: 2 / 1

13. BIRTHPLACE OF MOTHER (State or Country): 9 / 1

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Martin Gumwalt
(Address) Grangeville

15. Filed Nov 1 1920 G S Stocklin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920 to Oct 6 1920 that I last saw her alive on Sept 1 1920, and that death occurred on the date stated above, at 12 15 M.
The CAUSE OF DEATH* was as follows:
Sarcoma of left eye
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G S Stocklin M. D.
10/8 1920 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Denver	Oct 7 1920

20. UNDERTAKER	ADDRESS
E. S. Hancock	Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32004

Registered No. .....

1. PLACE OF DEATH.

County of Idaho

City of Kamiah

Registration District No. 29

Primary Registration District No. 7478

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bryan Clarence Wood

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH. Feb (Month) 18 (Day) 1915 (Year)

7. AGE 2 Yrs. 8 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Co Ida

10. NAME OF FATHER W. A. Wood

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Ora Taylor

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. A. Wood
(Address) Kamiah Ida

15. Filed 10/24 1921

C. J. Johnson
Local Registrar

SYMS - YORK CO., PTRS. & SOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 19 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 13th 1921, to Oct 1921, that I last saw h[illegible] alive on Oct. 15th 1921, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Uremia Colitis

(Duration) ..... Yrs. 1 mos. 4 ds.

Contributory (Secondary) Congenital Mitral Insuf.

(Duration) Birth yrs. ..... mos. ..... ds.

(Signed) C. H. Boysen M. D.

Oct 24 1921 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Woodland Ida. DATE OF BURIAL 10/24/1921

20. UNDERTAKER C. J. Johnson ADDRESS Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 4928
File No. 32005
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Harrisburg (near Ramsdell)
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dairly Craig

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Whit.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Singl

6. DATE OF BIRTH. July (Month) 10 (Day) 20 (Year)

7. AGE: ..... Yrs. 3 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Child
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Owyhee Co Ida

10. NAME OF FATHER Stephen M Craig

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Anna V Van Hise

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) S M Craig
(Address) Woodland Ida

15. Filed 10/25 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23 1920, to Oct. 23rd 1920, that I last saw him alive on Oct. 23rd 1920, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Lobar Pneumonia fever

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. A. Bryan M. D.
Oct 25 1920 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodland Cem
DATE OF BURIAL: 10/25 1920

20. UNDERTAKER: E J Johnson
ADDRESS: Kamiah Ida.

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

32066

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 28

Registered No. .....

1. PLACE OF DEATH.

County of Idaho

City of Kenteville

Registration District No. 105

Primary Registration District No. 2183

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Huttmann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH. Oct (Month) 9 (Day) 1841 (Year)

7. AGE: 79 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Huttmann Jr.

(Address) Kenteville Idaho

15.

Filed Oct 10 1920

H B Blake
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from for many yrs 191..., to ... 191..., that I last saw him alive on July 7th 1920, and that death occured on the date stated above, at 7.40 P.M.

The CAUSE OF DEATH* was as follows:

Causes (natural) Unknown

.....(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary): Senile debility

.....(Duration 7 yrs. ... mos. ... ds.

(Signed) H B Blake M. D.

Oct 10 1920 (Address) Cottonwood Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kenteville Idaho — DATE OF BURIAL: Oct 11 1920

20. UNDERTAKER: A. H. Marr — ADDRESS: Cottonwood

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 32007
Registered No. 97

1. PLACE OF DEATH.
County of Idaho
City of Kooskia
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Persis Williams

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow
6. DATE OF BIRTH. September (Month) 17 (Day) 1833 (Year)
7. AGE: 87 Yrs. ..... Mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: M. F. Woodward
11. BIRTHPLACE OF FATHER (State or Country): Vermont
12. MAIDEN NAME OF MOTHER: Persis Woodward.
13. BIRTHPLACE OF MOTHER (State or Country): New Hampshire
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. J. Williams
(Address) Kooskia
15. Filed Nov 1 1920 J. W. Webb Kinyon Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
No medical attendant
Supposed From Arterio Sclerosis
and Chronic Interstitial Nephritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Webb Kinyon M. D.
19 20 (Address) Kooskia Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kooskia Cemetery — DATE OF BURIAL: Oct 14 1920
20. UNDERTAKER: Geo Tremaine — ADDRESS: Kooskia Idaho

BYRD - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
File No. 32008
Registered No. 96

1. PLACE OF DEATH.
County of Idaho
City of Stites
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sara Elizabeth Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	Married (or Widowed)

6. DATE OF BIRTH. Feb (Month) 10 (Day) 1872 (Year)

7. AGE 48 Yrs. 8 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Teacher
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Henry H Williamson

11. BIRTHPLACE OF FATHER (State or Country) Vermont

12. MAIDEN NAME OF MOTHER Mary Williams

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mildred A Arnold
(Address) Grangeville Idaho

15. Filed Oct-15 1920 J M Weber Kinnes Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 10th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1920, to Oct 10 1920, that I last saw her alive on Oct 10 1920, and that death occured on the date stated above, at 9 30 P M.

The CAUSE OF DEATH* was as follows:
Attack of intestinal grippe with general exhaustion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H N Nsmith M. D.
Oct 17 1920 (Address) Stites Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Grangeville — DATE OF BURIAL Oct 13 1920

20. UNDERTAKER Geo Tierney — ADDRESS Kooskia

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

32009

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
(No. ..... St.)

File No. 3
Registered No. 71

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jane Scirchetti

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH.
Aug (Month) 23 (Day) 1920 (Year)

7. AGE
..... Yrs. 1 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Sam Scirchetti

11. BIRTHPLACE OF FATHER
(State or Country) Italy

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sam Scirchetti
(Address) Harrison Idaho

15.
Filed Nov 1 1920
J. M. Tenney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Oct 18 1920, that I last saw her alive on Oct 18 1920 and that death occured on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Gastro enteritis

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Tenney M. D.
10-19-20 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191.....

20. UNDERTAKER None | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 726 32010

Primary Registration District No. 2204

File No. 3

Registered No. 69

1. PLACE OF DEATH.

County of Kootenai

City of Harrison

(No. .... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susana Stillman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. April 23 1841
(Month) (Day) (Year)

7. AGE: 79 Yrs. 5 Mos. 15 ds.

IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Smith

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Susana

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J E Wrean
(Address) Rt 1 Box 1 Harrison

15. Filed Oct 15 1920 J M Tenney Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 14 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1920, to Oct 1920, that I last saw her alive on Oct 14 1920 and that death occured on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Senility

.....(Duration) .....Yrs. .....mos. .....ds.

Contributory (Secondary)

.....(Duration) .....yrs. .....mos. .....ds.

(Signed) J M Tenney M. D.

10 15 1920 (Address) Harrison Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER Matilda Ketchum | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRON-YORK CO., PTRS. & ENGS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30

City of Coeur d'Alene (No. 518, Lake Side Ave St.) — Primary Registration District No. 1051

File No.

Registered No. 83

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beulah Jeanne Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	Single

6. DATE OF BIRTH: Sept (Month) 9 (Day) 1911 (Year)

7. AGE: 9 Yrs. 1 Mos. 13 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: James Smith

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Bess Jeanne

13. BIRTHPLACE OF MOTHER (State or Country): Okla.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Smith
(Address) Coeur d'Alene Ida

15. Filed Nov 4, 1920 — D D Drenna, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 10 1920 to Oct. 22 1920, that I last saw h. alive on Oct. 22 1920, and that death occurred on the date stated above, at 1030 AM.

The CAUSE OF DEATH* was as follows:
Tuberculous Meningitis.

(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary): No contributory cause found

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John O Wood M. D.
Oct 25 1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. 6 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Oct 23 1920

20. UNDERTAKER: P B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

32012

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
(No. ..... St.)
File No. .....
Registered No. 803

1. PLACE OF DEATH
County of Kootenai
City of Coeur d Alene

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dinah Shockley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word)

6. DATE OF BIRTH: Feb (Month) 7 (Day) 1847 (Year)

7. AGE: 73 Yrs. 8 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: William Shockley

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dan Shockley
(Address) Coeur d Alene Ida

15. Filed Nov 4 1920 D. O'Dreuna
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1920, to Oct 20 1920
that I last saw h.. alive on Oct 20 1920,
and that death occurred on the date stated above, at 4:40 P. M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.
(Signed) W N Hoeden M. D.
10/23 1920 (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 9 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: Oct 23 1920

20. UNDERTAKER: [illegible] — ADDRESS: Coeur d Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1051

(No. 114 Coeur d'Alene St.)

File No. 32013

Registered No. 832

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elena Carlson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: 11 (Month) 2 (Day) 1863 (Year)

7. AGE: 56 Yrs. 11 Mos. 19 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: — Larson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elmer Nelson

(Address) 111 E. D'Alene Ave.

15. Filed Nov 4 1920 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920 to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH was as follows: Had No Physician Paralysis

Stroke Once

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Drennan M. D.

10/21/1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Lem. C. D. A. | DATE OF BURIAL: 10-23 1920

20. UNDERTAKER: Casady | ADDRESS: C'Dalene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32014
Registered No. 851

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 1202 Lakeside St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alphretta Hallows
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: 12 (Month) 20 (Day) 1853 (Year)

7. AGE: 66 Yrs. 9 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Jos. Parson

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Abba Janes

13. BIRTHPLACE OF MOTHER (State or Country): Canada,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos Hallows
(Address) 1202 Lakeside Ave.

15. Filed Nov 4, 1920 D D Drennan
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 7, 1920 to Oct 17 1920 that I last saw h.. alive on Oct 17 1920 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Dropsy.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Drennan M. D.
Oct 17 1920 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Forest-Cem. C'Dalene — DATE OF BURIAL: 10-17 1920

20. UNDERTAKER: C Cassedy — ADDRESS: C'Dalene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32016
Registered No. 849

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 1602, 3rd St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lena Belle McDonald

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 15 (Day) 1903 (Year)

7. AGE: 17 Yrs. 3 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Thomas Krogen

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Mary Sawley

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary Krogen.
(Address) Bayorkin Idaho Co.

15. Filed Nov 4 1920 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) [redacted] (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1920, to Oct 6 1920, that I last saw h[illegible] alive on Oct 6 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

[redacted] Hemorrhage (Puerperal)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.
Oct 8 1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. C D Alene | DATE OF BURIAL: 10-8 1920

20. UNDERTAKER: C. Cassedy | ADDRESS: C D Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32017
Registered No. 878

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo Wilbur Polk

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: Oct 6 (Month) (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many — hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Geo. Polk

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Myrtle Irving

13. BIRTHPLACE OF MOTHER (State or Country) Colorado.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bertha Irving,
(Address) 811-C.D.A. St. Coeur d'Alene, Ida

15. Filed Nov. 4 1920 D D Dreuna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 6 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from [redacted] 19..., to Oct 6 1920, that I last saw [redacted] alive on Oct 6 1920, and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Premature birth

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) 9 yrs. ....mos. ....ds.

(Signed) [signature] M. D.

10/8 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. C.D.Alene | DATE OF BURIAL: 10-9 1920

20. UNDERTAKER: C. Carredy | ADDRESS: C D'alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32018
Registered No. 877

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 730 Military Drive St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Annie Amelia Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 1 (Day) 1886 (Year)

7. AGE: 34 Yrs. 6 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: John Swanson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Lottie Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emil Johnson
(Address) Coeur d'Alene

15. Filed Oct 4, 1920 D D Dreman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 19 1920, to Oct 5 1920, that I last saw h.er alive on Oct 5 1920, and that death occurred on the date stated above, at 11:15 M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) / Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) C. J. Thurston M. D.
10/9 1920 (Address) Coeur d' Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 4 days. In the State 14 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: 10/10 1920

20. UNDERTAKER: R B Mooney
ADDRESS: Coeurdalene Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 1051 - 7051
File No. 32019
Registered No. 20

1. PLACE OF DEATH
County of Kootenai
City of .....
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eileen V. St Germain
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): S

6. DATE OF BIRTH: August 1 1919 (Month) (Day) (Year)

7. AGE: ..... Yrs. 10 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Walter St Germain

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Lucile Rivers

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Franklin
(Address) Bellmont

15. Filed 11/1 1920. Frank Wenz Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 20, 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 8. 1920 to Oct. 20. 1920
that I last saw h.r alive on Oct. 19. 1920
and that death occurred on the date stated above, at 6.[illegible] M.
The CAUSE OF DEATH* was as follows:
Acute Bronchio Pneumonia

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Whooping Cough
(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) Frank Wenz M. D.
10/21 1920 (Address) Rathdrum, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Athol Ida | DATE OF BURIAL: Oct 22 1920

20. UNDERTAKER: C W Stam Rathdrum | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32020

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai — Registration District No. 30 — File No. 1

City of Post Falls Ida (No. R.F.D No 1, St.) — Primary Registration District No. 1051. 2051 — Registered No. 21

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Castella Wenck

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: M (Write the word.)

6. DATE OF BIRTH: March (Month) 29 (Day) 1853 (Year)

7. AGE: 67 Yrs. 7 Mos. 25 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Jasper Weber

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Hannah M. Washburn

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. C. Crumpacker
(Address) Spokane 423 Camilac

15. Filed 11/1 1920 — Frank Wenz, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from — 19 — to — 19 —, that I last saw h— alive on — 19 —, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Heart Disease

(Duration) 10 Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration) — yrs. — mos. — ds.

(Signed) F L McCauley M. D.

10/25 1920 (Address) Post Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Post Falls Idaho — DATE OF BURIAL: Oct 26 1920

20. UNDERTAKER: C. W. Stone — ADDRESS: Rathdrum Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32021

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of .....

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1051. 2051

(No. ....., ... St.)

File No. 1

Registered No. 22

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dora Martin

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 16 (Day) 1886 (Year)

7. AGE: 34 Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Va

10. NAME OF FATHER: John Cronenberg

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Arthur Martin

(Address) Athol, Idaho

15. Filed 11/1. 1920 Frank Wm Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 29th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 19. 1920 to Oct. 29 1920, that I last saw h.r. alive on Oct 29 1920, and that death occurred on the date stated above, at 10 2 M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Nephritis and Pregnancy

(Duration) ..... yrs. 7 mos. ..... ds.

(Signed) Frank Wm M. D.

10/30 1920 (Address) Rathdrum, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Athol — DATE OF BURIAL: Oct 30 1920

20. UNDERTAKER: A W Estes Rathdrum — ADDRESS: Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32022
Registered No. 130

1. PLACE OF DEATH.
County of Latah
City of Garfield, Wash.

Registration District No. 61
Primary Registration District No. 2141
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Mrs. Lucinda Jameson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	widowed

6. DATE OF BIRTH: Dec. (Month) 18. (Day) 1839 (Year)

7. AGE: 80 yrs. 10 mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Arkansaw

10. NAME OF FATHER Jos. Rea

11. BIRTHPLACE OF FATHER (State or Country) N. C.

12. MAIDEN NAME OF MOTHER Sarah Robertson

13. BIRTHPLACE OF MOTHER (State or Country) Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. H. Horton
(Address) Garfield, Wash.

15. Filed Dec 30 1920 W. H. Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1920, to Oct 27 1920 that I last saw her alive on Oct 27 1920 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

Contributory (Secondary) Cerebral Hemorrhage

(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) E. Freed M. D.

Oct 27 1920 (Address) Garfield Wash

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Silver Creek, Wash.	Oct. 29 1920

20. UNDERTAKER	ADDRESS
F. L. Swim	Garfield, Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 2141
File No. 32023
Registered No. 2929

1. PLACE OF DEATH
County of Latah
City of Viola
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. H. Kleinsmith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Aug (Month) 29 (Day) 1920 (Year)

7. AGE: Yrs. 2 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wm. Kleinsmith

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Katie Schollenberg

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm H. Kleinsmith
(Address) .....

15. Filed 10/28 1920 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920, to Oct 24 1920 that I last saw h.... alive on Oct 24 1920, and that death occurred on the date stated above, at 1 A. M.

The CAUSE OF DEATH* was as follows:
Hooping Cough
(Whooping cough)

(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Adair M. D.
Oct 25 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Viola — DATE OF BURIAL: Oct 26 1920

20. UNDERTAKER: Ellis Price — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32024

Registered No. 128

1. PLACE OF DEATH

County of Latah

City of Moscow

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Karl W. Hullberg.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH Oct (Month) 6 (Day) 1867 (Year)

7. AGE 53 Yrs. ..... Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Sweden

10. NAME OF FATHER Karl G. Hullberg

11. BIRTHPLACE OF FATHER (State or Country) Sweden

12. MAIDEN NAME OF MOTHER Anna Berggren

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs K. W. Hullberg

(Address) Moscow

15. Filed Oct 25 19 20 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 12th 1920, to Oct. 24 - 1920 that I last saw h.... alive on Oct. 24 1920, and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Exophthalmic Goiter

(Duration) ..... Yrs. 10 mos. — ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. Harris M. D.

10/25 1920 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	10/26 1920

20. UNDERTAKER	ADDRESS
Glen Grice	Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 32055
Registered No. 127

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sue Ella Hall.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 15 (Day) 1859 (Year)

7. AGE: 61 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Sparger

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Sinai Carlyle.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. W. Hall
(Address) Moscow

15. Filed 10/24 1920 W. H. Carithers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 17 1920, to Oct 22 — 1920 that I last saw h.er alive on Oct. 22 — 1920, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

General Paralysis of the Insane

(Duration) 1 Yrs. 6 mos. — ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Curtis M. D.
10/24 1920 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 10/25 1920

20. UNDERTAKER: Glenn Grice ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 32026
Registered No. 126

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samual G. Humphrey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 16 (Day) 1844 (Year)

7. AGE: 76 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Joseph Humphrey

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Green

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. S. G. Humphrey
(Address) Moscow

15. Filed 10/19 1921 — W. H. Matthews, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 13. 1920, to Oct. 18 1920, that I last saw him alive on Oct. 18 1920, and that death occurred on the date stated above, at 9 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) — Yrs. — mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. Wirt M. D.
10/19 1921 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 10/21 1920

20. UNDERTAKER: Flew Funeral Home — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... St.)

File No. 32027
Registered No. 125

1. PLACE OF DEATH

County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Duggan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Widow (or widower)

6. DATE OF BIRTH Jan (Month) 23 (Day) 1867 (Year)

7. AGE 53 Yrs. 8 Mos. 22 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Indiana

10. NAME OF FATHER John Farrell

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Anna Murphy

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Katherine Duggan
(Address) Moscow Ida

15. Filed 10/17 19.. W. H. Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 15 (Day) 20 (Year) 19..

17. I HEREBY CERTIFY, That I attended deceased from Sept 8 1920 to Oct 15 1920 that I last saw h.. alive on Oct 15 1920, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(Duration) ..... Yrs. 1 mos. 5 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. 1 mos. 18 ds.

(Signed) Virgil M. Gilchrist M. D.

10/17 19 20 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Moscow — **DATE OF BURIAL** 10/18 19 20

20. UNDERTAKER Hill — **ADDRESS** Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 101
Primary Registration District No. 2141
File No. 32029
Registered No. 123

1. PLACE OF DEATH
County of Latah
City of Viola (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John P. Blackenburg
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb 1 (Month) 2 (Day) 1865 (Year)

7. AGE: 55 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin.

10. NAME OF FATHER: Charles Blackenburg.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Anna Dwyer.

13. BIRTHPLACE OF MOTHER (State or Country): Ireland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Abbie Blackenburg
(Address): Viola Idaho

15. Filed Oct 4 1920 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/15 1920, to 10/4 1920, that I last saw h..... alive on 10/4 1920 and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:
Gastric Carcinoma
(Duration) 2 years mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas. L. Gibbons M. D.
10/4 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Viola Idaho. DATE OF BURIAL: Oct 6 1920

20. UNDERTAKER: Glen Price ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32030

Registration District No. 12
Primary Registration District No. 2142
(No. ....., ... St.)
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Genesee
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Herman Theodore Nebelsieck
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 22 (Day) 1846 (Year)

7. AGE: 74 Yrs. 4 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): ~~Bielefeld~~ Waldeck Germany

10. NAME OF FATHER: Theodore Nebelsieck

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Elvina Koeder

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) E. Nebelsieck
(Address) Genesee.

15. Filed Oct. 16 1920 W. F. Ehrem
Local Registrar

STUB - YORK CO., PTG. & BKBG. 24655

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 13th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 18 1920, to Oct. 14th 1920, that I last saw him alive on Oct. 14 1920 and that death occured on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. F. Ehrem M. D.

Oct 16 1920 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Genesee ~~Idaho~~ | DATE OF BURIAL: Oct 17 1920

20. UNDERTAKER: F. E. Lambert | ADDRESS: Genesee

FORM V. S. No. 5-25 M. 1-16-13

32031

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah

City of Bovill

Registration District No. 66

Primary Registration District No. 2146

(No. ....., Bovill Hospital St.)

File No. 11

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Welbur I Topham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. Feb. (Month) 23 – (Day) 1899 (Year)

7. AGE 21 Yrs. 7 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Woodsman

(b) General nature of industry, business, or establishment in which employed (or employer)..... Rutledge Timber Co.

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER Horace Irving Topham

11. BIRTHPLACE OF FATHER (State or Country) ~~Ohio~~ Michigan

12. MAIDEN NAME OF MOTHER Margerete Teichman

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Margerete Topham

(Address) R 78 Nat Orchard Ave Spokane

15.

Filed 10 24 1920

Miss J. C. Gibson
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 22 – (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 – 1920, to Oct 22 1920, that I last saw him alive on Oct 22 1920 and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Basel Skull Fracture

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H. Gibson M. D.

10/22/1920 (Address) Bovill Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos. 2 days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Spokane Wn.

19. PLACE OF BURIAL OR REMOVAL Palouse Wash. DATE OF BURIAL .....191.....

20. UNDERTAKER E. Mc. Drewes ADDRESS Palouse Wash

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 68
Primary Registration District No.
File No. 32032
Registered No.

1. PLACE OF DEATH
County of Latah
City of Juliaetta
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Hoth Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: June – 3 – 1847 (Month) (Day) (Year)

7. AGE: 73 Yrs. 4 Mos. 14 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miller & Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Retired,

9. BIRTHPLACE (State or Country): Barbour Co. W. Va.

10. NAME OF FATHER: John G Johnson

11. BIRTHPLACE OF FATHER (State or Country): Barbour Co. W. Va.

12. MAIDEN NAME OF MOTHER: Catharine Parsons

13. BIRTHPLACE OF MOTHER (State or Country): Barbour Co W. Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Amanda Alexander
(Address): Juliaetta Idaho

15. Filed Sept 29 1920 R H Pepple, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. 27th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1st 1920 to Sept 24th 1920 that I last saw h.im alive on Sept 24th 1920 and that death occurred on the date stated above, at 4. P.M.

The CAUSE OF DEATH* was as follows:

Cancer of the Stomach

(Duration) 1 Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W. A. Rothwell M. D.
Sept 28 1920 (Address) Kendrick Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash. DATE OF BURIAL: 9/29 1920

20. UNDERTAKER: H. R. Merchant ADDRESS: Clarkston Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32033
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 41
Primary Registration District No. 2116

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

2. FULL NAME Earnest Cleveland Lewis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: March 27th 1852
(Month) (Day) (Year)

7. AGE: 68 Yrs. 7 Mos. 16 ds.
IF LESS THAN 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: quartz miner and teamster
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Thomas M. Lewis

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Louisa Hughes

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ethel M. Lewis
(Address) Salmon, Idaho

15.
Filed 11/1.0 1920 M. D. Greene
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 16th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 10 1920 to Oct 16th 1920
that I last saw him alive on 16th of Oct. 1920
and that death occurred on the date stated above, at 9.10 P.M.

The CAUSE OF DEATH* was as follows:
Brights disease
(Duration) ..... Yrs. 0 mos. ..... ds.
Contributory (Secondary) Syphilis
(Duration) ..... Yrs. 30 mos. ..... ds.
10/16 1920 (Signed) F. S. Myhr M. D.
(Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 10-18-1920

20. UNDERTAKER: Hall & Doe & Co. — ADDRESS: Salmon Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32034
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriet Maria Mills

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Dec (Month) 15 (Day) 1837 (Year)

7. AGE: 82 Yrs. 7 Mos. 15 ds. IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) House wife

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER — — Barker

11. BIRTHPLACE OF FATHER (State or Country) do not know

12. MAIDEN NAME OF MOTHER do not know

13. BIRTHPLACE OF MOTHER (State or Country) do not know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lemuel E. Bowen
(Address) Salmon Idaho

15.
Filed 11/1.0 1920. M. D. Greene
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920 to Nov 2 1920 that I last saw h[illegible] alive on Nov 1 1920 and that death occurred on the date stated above, at 6:15 P.M.

The CAUSE OF DEATH* was as follows:
Bronchio pneumonia
.....
.....
.....(Duration) 10 days mos. ..... ds.
Contributory (Secondary) Senile debility
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Chas. F. Hamma M. D.
Nov 3 1920 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Ida. DATE OF BURIAL ..... 191...

20. UNDERTAKER: W. C. Peebles ADDRESS Salmon Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32035
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alexander W. Pattison

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widower

6. DATE OF BIRTH. October 11th 1850
(Month) (Day) (Year)

7. AGE: 70 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired undertaker
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Robert Pattison

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Rosa Gilbert

13. BIRTHPLACE OF MOTHER (State or Country): Irland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Geo. Coufer
(Address) Salmon Idaho

15.
Filed 10/11 ..... 192 D. M. D. Greene
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 17th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
..... Accidently
drowned in a Shallow well.
He had fallen head first into the hole.
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) W. E. Jaeblon Coroner ~~M. D.~~
10-20 1920 (Address) Salmon Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days, In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery
DATE OF BURIAL: 10-21st 1920

20. UNDERTAKER: Wm C Jaeblon
ADDRESS: Salmon Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32056
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 41
Primary Registration District No. 2 W6
(No. ....., ... St.)

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Philip Fredrick Dunlap

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.):

6. DATE OF BIRTH. June (Month) 13th (Day) 1920 (Year)

7. AGE ..... Yrs. 3 Mos. 14 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER Tullius Philip Dunlap

11. BIRTHPLACE OF FATHER
(State or Country) Montana

12. MAIDEN NAME OF MOTHER Ella V Simons

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tullius T. Dunlap
(Address) Salmon Idaho

15.
Filed 11/1.D. ..... 1920 M. D. Greene
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 25th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1920 to Sept 25 1920
that I last saw h[illegible] alive on Sept 25 1920
and that death occurred on the date stated above, at 8.0 M.

The CAUSE OF DEATH* was as follows:

Nephritis
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) ..... B. Wright M. D.
Sept 25 1920 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery — DATE OF BURIAL 9-26 1920

20. UNDERTAKER W C Doebler — ADDRESS Salmon Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32037
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

2. FULL NAME Elizabeth Ann Yearian

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. March (Month) 17 (Day) 1840 (Year)

7. AGE: 80 Yrs. 5 Mos. 13 ds.
IF LESS THAN 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home, Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Tennessee

10. NAME OF FATHER: Hodge S. Stroud

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Amy Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Nora Y. Whitwell
(Address): Salmon, Idaho

15.
Filed 11/10 1920 M. D. Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug 30th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 20th 1920 to Aug 30 1920
that I last saw her alive on Aug 30 1920
and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

old age

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

10/30 1920 (Signed) F. S. Wright M. D.
(Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Junction Ida Cemetery — DATE OF BURIAL: 8-31st 1920

20. UNDERTAKER: Wm C. Beebe — ADDRESS: Salmon, Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32038
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 41
Primary Registration District No. 2116

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

2. FULL NAME Helen Bloomburg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Aug 24th (Month) (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 12 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) United States

10. NAME OF FATHER Walter Bloomburg

11. BIRTHPLACE OF FATHER (State or Country) Not known

12. MAIDEN NAME OF MOTHER Helen Daniels

13. BIRTHPLACE OF MOTHER (State or Country) United States

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. W. Clark
(Address) Leadore, Ida.

15. Filed 11/10 1920. M. D. Greene Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 4th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1920 to Sept 4 1920
that I last saw h.e alive on Sept 4 1920
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Premature — two months, premature —
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Chas. F. Hamm M. D.
Sept 5 1920 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Salmon Cemetery — DATE OF BURIAL 9-5" 1920

20. UNDERTAKER Wm C Faulder — ADDRESS Salmon Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32039
Registered No. 17

1. PLACE OF DEATH
County of Lewis
City of Craigmont R2D
If death occurred away from usual residence, give facts called for under special information.

Registration District No. 62
Primary Registration District No. 2129
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Lane Meeks

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: October (Month) 6 (Day) 1855 (Year)

7. AGE: 65 Yrs. — Mos. 18 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Joseph L. Meeks

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. I. Anderson
(Address) Craigmont Ida.

15. Filed 10/25 19 20 R. B. Durell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 24 (Day), 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1920, to Oct 23, 1920, that I last saw him alive on Oct. 23, 1920, and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — Yrs. — mos. 7 ds.

Contributory (Secondary) Chronic Nephritis, Asthma

Prostatic obstruction (Duration) ? yrs. — mos. — ds.

(Signed) John J. Clark M. D.
10/25 1920 (Address) Craigmont Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fiddler Cemetery — DATE OF BURIAL: 10/25 1920

20. UNDERTAKER: Star Hdwe & Imp Co — ADDRESS: Craigmont.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32040

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis

City of Kamiah Ida

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....

Primary Registration District No. 2428

(No. .... St.)

2. FULL NAME Godfrey Jarbo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. 25 1865
(Month) (Day) (Year)

7. AGE: 54 Yrs. 10 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer) Hotel Keeper

9. BIRTHPLACE (State or Country) Ottowa Canada

10. NAME OF FATHER Leon Jarbo

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER L Baushaw

13. BIRTHPLACE OF MOTHER Canada (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) F Jarbo
(Address) Kamiah Ida

15. Filed 10/18 1920 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 16 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 16th 1920, to Oct. 16th 1920, that I last saw h— alive on Sudden illness 1917, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Hydrapericardis

(Duration) Hours Previous

Contributory (Secondary) Pneumonia (Duration ..... yrs. ..... mos. ..... ds.

(Signed) B Bryan M.D.

19[illegible] 19[illegible] (Address) Kamiah Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Dot Cem Kamiah Ida — DATE OF BURIAL 10/18 1920

20. UNDERTAKER C J Johnson — ADDRESS Kamiah

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
(No. ....., ... St.)

File No. 32041
Registered No. .....

1. PLACE OF DEATH.
County of Lemhi
City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John M. Clark

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. March 4 1866
~~Oct~~ (Month) ~~25~~ (Day) ~~1920~~ (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... R.R. Agent
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Canton Miss

10. NAME OF FATHER: Stephen Clark

11. BIRTHPLACE OF FATHER (State or Country): St Louis Mo

12. MAIDEN NAME OF MOTHER: Katharine Welsh

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mary Agnes Clark
(Address) Dietrich Ida.

15. Filed Oct 25 1920
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to Oct 25 1920, that I last saw h— alive on Oct 25 1920, and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Gastric Ulcer

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Arteriosclerosis
(Duration 2 yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
Oct 25 1920 (Address) Shoshone Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos. 3 days. In the State 10 yrs.....mos.....days
Where was disease contracted if not at place of death? District Ida.
Former or usual residence District Ida

19. PLACE OF BURIAL OR REMOVAL: Kearney Neb — DATE OF BURIAL: .....191.....

20. UNDERTAKER: O J Brennan — ADDRESS: Shoshone Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32043

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Madison

City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

Registration District No. (illegible)

Primary Registration District No. 217

(No. ..... St.)

File No. 79

Registered No. ....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Stanley B. Wilding.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. **DATE OF BIRTH** November (Month) 18th (Day) 1919 (Year)

7. **AGE** ... Yrs. -- Mos. 11 ds. 5

IF LESS than 1 day how many ... hrs. or ... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** Idaho (State or Country)

10. **NAME OF FATHER** Joseph A. Wilding.

11. **BIRTHPLACE OF FATHER** Utah. (State or Country)

12. **MAIDEN NAME OF MOTHER** Eliza Barnes

13. **BIRTHPLACE OF MOTHER** Idaho. (State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Joseph A Wilding

(Address) Rexburg Ida

15. Filed 10-24 1920 G G Espe Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** October (Month) 23 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** April 1920, to Oct 20th 1920, that I last saw h/M alive on Oct. 20th 1920, and that death occurred on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Exaustion from Malnutrition

(Duration) ... Yrs. 7 mos. - ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Lorna F. Tuck M. D.

10/26 1920 (Address) Rexburg Idaho.

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Sugar City — **DATE OF BURIAL** Oct. 26 1920

20. **UNDERTAKER** John Phillips — **ADDRESS** Rexburg.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

32044

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2170
File No. 78
Registered No. .....

1. PLACE OF DEATH.
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy White
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. October (Month) 1 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 11 ds.
If LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: -
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas R. White

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Annabelle Hope

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Thomas R. White
(Address) Rexburg Idaho

15. Filed 10/13 1920
H. G. Cooke
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
October (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 11 1920, to Oct 11 1920, that I last saw her alive on Oct 11 1920, and that death occured on the date stated above, at 9.15 P. M.

The CAUSE OF DEATH* was as follows:
Hemorrhage from umbilicus

(Duration) Yrs. ..... mos. 11 ds.
Contributory (Secondary) Hemophelia
(Duration) yrs. ..... mos. 1 ds.

(Signed) O. O. Martin M. D.
10-12 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: Oct. 13 1920

20. UNDERTAKER: John M. Richards
ADDRESS: Rexburg. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STATE - YORK CO., PTGS. & ENGS. 24954

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 32047
Registered No. 4553

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 347, 19th St. 21)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bessie Cormaney

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Single

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1907 (Year)

7. AGE: 13 Yrs. Mos. 12 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oklahoma

10. NAME OF FATHER: A J Cormaney

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Sarah McCarthy

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Cormaney
(Address) 347 19th St. L

15. Filed Nov 9 1920 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 12th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10th 1920, to Oct 12th 1920, that I last saw h. er alive on Oct 11th 1920, and that death occurred on the date stated above, at 3 P.M.
The CAUSE OF DEATH* was as follows:

Acute Parenchymatous nephritis
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary) Dont know
(Duration) yrs. mos. ds.
(Signed) O. C. Carson M. D.
19 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho — DATE OF BURIAL: Oct 14 1920

20. UNDERTAKER: W B Williamson — ADDRESS: Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1009

(No. 719, 4th St.) — File No. 32048

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Minnie Gute — Registered No. 295-6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Divorced

6. DATE OF BIRTH — Sept. (Month) 12. (Day) 1874 (Year)

7. AGE — 46 Yrs. 1 Mos. 9 ds. — IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Formal Employee
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Wis

10. NAME OF FATHER — Waltyer

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Minnie Williamena

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James Baskett
(Address) Lewiston, Ida. 3006 Main

15. Filed Nov 9 1920 — Susan E Bruce, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH — Oct (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to Oct 21 19 20
that I last saw h... alive on ... 19...
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

Coronary Embolism
Presumably Heart Failure
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) O C Pearson, M. D.
19... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewiston Idaho	Oct 24 1920
20. UNDERTAKER	ADDRESS
W B Williamson	Lewiston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Corrow

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce — Registration District No. 96

City of Lewiston — Primary Registration District No. 1009

(No. [redacted] Hospital St.) — File No. 32049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo W Bubb — Registered No. 45-7

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 7 (Day) 1895 (Year)

7. AGE: 25 Yrs. 3 Mos. 14 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mont

10. NAME OF FATHER: R R Bubb

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Florence Blythe

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A J Jordan
(Address)

15. Filed Nov 9 1920 — Susan E Bruce, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1920 to Oct 21 1920, that I last saw him alive on Oct 21 1920 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Chron Nephritis + Cystitis
following traumatic spine etc

(Duration) 3 Yrs. 10 mos. ..... ds.

Contributory (Secondary): Same

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Edgar L White M. D.

Oct 23 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: T. D. Nassar — DATE OF BURIAL: Oct 24 1920

20. UNDERTAKER: Lewiston T. D. Nassar — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

F W White

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 32050
Registered No. 45-8

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Mathews Buckley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 26th (Day) 1895 (Year)

7. AGE: 25 Yrs. 1 Mos. No ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Walla Walla, Wash

10. NAME OF FATHER: Mike Buckley

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Lucelia Levell

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W.M. Buckley
(Address) Clarkston, Wash.

15. Filed Nov 9 1920 Susan E Bruce
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1920, to Oct 26 1920
that I last saw h~~as~~ alive on Oct 26 1920
and that death occurred on the date stated above, at 9:20 P.M.
The CAUSE OF DEATH* was as follows:
General peritonitis from ruptured appendix.
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Paul W Johnson M. D.
10/27 1920 (Address) Clarkston Wn

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 4 days. In the State ..... yrs. ..... mos. 4 days
Where was disease contracted if not at place of death? Washington
Former or usual residence Clarkston Wash

19. PLACE OF BURIAL OR REMOVAL: Walla Walla
DATE OF BURIAL: 10/29/20 1920

20. UNDERTAKER: H.R.Merchant
ADDRESS: Clarkston Wash.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1109

(No. St. Joseph's Hospital St.)

File No. 32051

Registered No. 959

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Forest Turner

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	single

6. DATE OF BIRTH: Sept (Month) 12 (Day) 1878 (Year)

7. AGE: 32 Yrs. 1 Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Millman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: T P Turner

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Eleanor Wilmot

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mary E. Turner

(Address) Kooskia, Idaho.

15. Filed Nov 9 1920 Susan E. Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1920, to Oct 27 1920, that I last saw h... alive on Oct 26 1920, and that death occurred on the date stated above, at 6.25 A.M.

The CAUSE OF DEATH* was as follows:

Shock following operation for Appendicitis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary): Hemorrhage from crushing

(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) H C Canaran M. D.

19..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kooskia Idaho — DATE OF BURIAL 19.....

20. UNDERTAKER: W B Williamson — ADDRESS Lewiston Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

AV Corrected

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 26

Primary Registration District No. 2069

File No. 32052

Registered No. 34

County of Oneida

City of Malad (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alta Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Child

6. DATE OF BIRTH

Sept (Month) 15 (Day) 1920 (Year)

7. AGE

..... yrs. ..... mos. 19 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Malad Idaho

10. NAME OF FATHER Edwin Williams

11. BIRTHPLACE OF FATHER (State or Country) Malad Idaho

12. MAIDEN NAME OF MOTHER Bertha Jones

13. BIRTHPLACE OF MOTHER (State or Country) Malad Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed. Williams Jr.

(Address) Malad Idaho

15.

Filed Oct 4 1920 R W Mauer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 to ..... 191..., that I last saw h. alive on Sept 19 1920 and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Convulsions due from unknown cause

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....

(Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Oct 5 1920 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Malad Idaho | DATE OF BURIAL Oct 6, 1920

20. UNDERTAKER Woodland Furniture Co | ADDRESS Malad

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2069
File No. 32053
Registered No. 35

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jeremiah Williams.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: April (Month) 16 (Day) 1854 (Year)

7. AGE: 66 Yrs. 6 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): 11

9. BIRTHPLACE (State or Country): Blackwood, Wales

10. NAME OF FATHER: William H Williams

11. BIRTHPLACE OF FATHER (State or Country): Blackwood, South Wales

12. MAIDEN NAME OF MOTHER: Mary Hodge

13. BIRTHPLACE OF MOTHER (State or Country): Blackwood South Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lewis Williams
(Address) Boise Idaho

15. Filed Nov 4 1920 R T Mercer M.D. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 1 1920, to Oct 27 1920 that I last saw h. alive on Oct 26 1920, and that death occurred on the date stated above, at 9P M.
The CAUSE OF DEATH* was as follows:
Diabetes.
(Duration) 2 Yrs. — mos. — ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Terrell M. D.
19 ..... (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Samaria Ida
DATE OF BURIAL: Oct. 29 1920

20. UNDERTAKER: P. E. Johnson
ADDRESS: Malad Ida

FORM V. S. No. 5-12 M. 6-15-17.

32054

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 9
Registered No. 158

1. PLACE OF DEATH
County of Power
City of American Falls, Idaho
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 23
Primary Registration District No. 2072
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas T. Carty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH.
Not Known (Month) 1 (Day) ..... (Year)

7. AGE Not Known ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Not Known

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed 11-4 1920. Richard F. Matt
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 17 (Day) 1920 (Year) 191...

17. I HEREBY CERTIFY, That I attended deceased from Life Extinct when I received him 191... to ..... 191...
that I last saw h... alive on ..... 191....
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows: Apoplexy (Cerebral Hemorrhage)
..... (Duration) 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Richard F. Matt M. D.
Oct 18. 1920 (Address) American Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL American Falls Idaho
DATE OF BURIAL Oct 25 1920 191...

20. UNDERTAKER A. O. Davis
ADDRESS American Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

32056 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 173
Primary Registration District No. 7701
File No. 36
Registered No.

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Geo. Lorenzo

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH
(Month) (Day) (Year)

7. AGE: 40 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Holland

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country): No information

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed Sep 21 1920 Geo. D Lester Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sep 19 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 19 1920 to Sep 19 1920 that I last saw h alive on 19, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Suicide. by Shooting self in chest with shot gun
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Geo. D Lester M. D.
9/21 1920 (Address) Kellogg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: 22 Sep 1920

20. UNDERTAKER: Thornhill Undertaker — ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

32057

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

1. PLACE OF DEATH
County of Shoshone
City of Kellogg, Idaho
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Elizabeth Graves

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Sept. (Month) 14 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 4 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... none .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Melville Fillmore Graves

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Mattie Goss

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Melville Fillmore Graves
(Address) Kellogg, Idaho, [redacted]

15. Filed 10/8/20 1920 Jno S Lashua
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Birth Sept 14 1920 to Sept 15 1920
that I last saw her alive on Sept 15 1920
and that death occurred on the date stated above, at 1. P. M.

The CAUSE OF DEATH* was as follows:
Cardiac weakness
.....
.....
.....
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Edema of Lungs
(Duration) ..... Yrs. ..... mos. 1 ds.
(Signed) E. E. Hardy M. D.
Oct 1 1920 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kellogg Idaho — DATE OF BURIAL Sept 16 1920

20. UNDERTAKER McShanker — ADDRESS Kellogg Idaho

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

32058 Shoshone

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 38
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Kellogg
City of Wardner
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ..... St.)

2. FULL NAME Sarah Jane Wilson

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH. Sept (Month) 22 (Day) 1864 (Year)
7. AGE: 56 Yrs. ..... Mos. 1 ds. IF LESS than 1 day how many .... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: Thomas Pitt
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Ann Jenkins
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna Gilgrass
(Address) Wardner
15. Filed 10/28 1920 Geo. S. Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept (Month) 23 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 19 1920 to Sept 20 1920
that I last saw her alive on Sept 20 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cancer of the Right Breast
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Consolidation Lung
(Duration) 10 Yrs. ..... mos. ..... ds.
(Signed) E. E. Sanders M. D.
Oct 5 1920 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Sept 25 1920
20. UNDERTAKER: Mc Manahin — ADDRESS: Kellogg Idaho

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

32059

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 37
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME Eliza Jane Barnhart

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. August (Month) 19 (Day) 1851 (Year)

7. AGE: 69 Yrs. —— Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Akron, Ohio

10. NAME OF FATHER Hamilton Bonham

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Sarah A. Wolf

13. BIRTHPLACE OF MOTHER (State or Country) Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Mae Thomas
(Address) Kellogg Idaho

15. Filed 10/18 1920 Jno S Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 21 1920 to Aug 24 1920 that I last saw h..... alive on Aug 24 1920 and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) H. C. Lindsay M. D.
10/5 1920 (Address) Kellogg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Kellogg Idaho — DATE OF BURIAL Aug 24 1920

20. UNDERTAKER M. C. Shanklin — ADDRESS Kellogg Ida.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

32060

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77

Primary Registration District No. 2176

File No.

Registered No. 30

1. PLACE OF DEATH

County of Teton

City of Victoria

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rhoda B. Hoel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Aug. 2nd. 840 (Month) (Day) (Year)

7. AGE: 80 Yrs. 2 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business or establishment in which employed (or employer): Domestic

9. BIRTHPLACE (State or Country): Bristol England.

10. NAME OF FATHER: John Bowen

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Sarah Reynolds.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Willia Fullmer
(Address) Teton Idaho

15. Filed 11/3 1920 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 1 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1920, to Nov 1 1920, that I last saw h[illegible] alive on Nov 1 1920 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
complicated by Acute Lobar
Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas F Martin M. D.

Nov 3 1920 (Address) Driggs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Logan, Utah. DATE OF BURIAL: 11/7 1920

20. UNDERTAKER: L O King ADDRESS: Driggs Ida.

FORM V. S. No. 3-25 M. 1-16-13

CERTIFICATE OF DEATH. 32061

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Teton
City of Driggs
(No. ....., ... St.)
Registration District No. 77
Primary Registration District No. 2176
File No. .....
Registered No. 29
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret L Wallace

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 9 (Day) 1847 (Year)

7. AGE: 46 Yrs. 4 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Geo A. Tuttle

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Martha Taylor

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W A Wallace
(Address) Driggs Idaho

15.
Filed Oct 12th 1920 — Martha Marks, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1920, to Sept 23 1920, that I last saw her alive on 23 Sept 1920, and that death occured on the date stated above, at 2 A M.
The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
(Duration) 15 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) H. H. Culbertson M. D.
Sept 25 1920 (Address) Driggs Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Driggs — DATE OF BURIAL: Sept 25 1920
20. UNDERTAKER: None — ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

32062

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Hansen (No. ..... St.)

Registration District No. 36

Primary Registration District No. .....

File No. .....

Registered No. 19

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sophia C. Sutiller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1 (Year)

7. AGE: 71 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Seaberg

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. C. Sutiller

(Address) Hansen, Ida.

15. Filed Oct 8 1920 J. M. Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1920, to Oct 7 1920, that I last saw h[illegible] alive on Oct 6 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) —

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Davis M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
removed	19.....
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

32063

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36

Primary Registration District No.

File No.

Registered No. 20

1. PLACE OF DEATH

County of Twin Falls

City of Hansen

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard W. Olsen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Sept 4 (Month) (Day) 1916 (Year)

7. AGE: Yrs. 13 Mos. 20 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Earl Richard Olsen

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Minnie Ferguson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl R. Olsen

(Address) Hansen, Idaho

15. Filed Oct 25 19 20

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 24 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1920, to Oct 24 1920 that I last saw h alive on 19 and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) K. M. Davis M. D.

Oct 25 1920 (Address) Hansen, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: 10-26 19 20

20. UNDERTAKER: J. E. Everett

ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5,25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 32065
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Jane Crowther

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word): Married

6. DATE OF BIRTH: Sept (Month) 27 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Burke.

10. NAME OF FATHER: A. F. Crowther

11. BIRTHPLACE OF FATHER (State or Country): Colo.

12. MAIDEN NAME OF MOTHER: Ethel M. Cluff

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. F. Crowther
(Address) Burke, Idaho.

15. Filed 10-5 1920 J. N. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1920 to Oct 5 1920 that I last saw h.. alive on Oct 3 1920 and that death occurred on the date stated above, at 8 A M.

The CAUSE OF DEATH* was as follows:

Baby was 9 lbs 10 weeks premature, Weighed 2½ lbs

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. N. Murphy M. D.

10/5 1920 (Address) Burke Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: — | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 7087
File No. 32066
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burley
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Ann Porter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Jan. (Month) 25 (Day) 1838 (Year)

7. AGE: 82 Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Joseph Jewell

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Hyde
(Address) Burley Idaho - Box 447

15. Filed 10-7 1920 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5, 1920, to Oct 6, 1920, that I last saw him alive on Oct 6, 1920, and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. H. Murphy M. D.
10-6 1920 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Cemetery — DATE OF BURIAL: 10/7 1920

20. UNDERTAKER: Smith & Sons — ADDRESS: Burley Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 7081
File No. 32067
Registered No.

1. PLACE OF DEATH
County of Twin Falls.
City of Burley.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Cecil Strader
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Feb. (Month) 28 (Day) 1912 (Year)

7. AGE 8 Yrs. 7 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER J. G. Strader

11. BIRTHPLACE OF FATHER (State or Country) Calf.

12. MAIDEN NAME OF MOTHER Lyda Thomas.

13. BIRTHPLACE OF MOTHER (State or Country) Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. G. Strader
(Address) .....

15. Filed 10-18 1920 J. A. Mumfley Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 17 1920, to Oct 17 1920, that I last saw h.... alive on Oct 17 1920, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:
Accidental. Buried under dirt from a cave-in.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) George Jennings M. D.
10-18 1920 (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burley Cemetery	10/19 1920
20. UNDERTAKER	ADDRESS
Neville & Sugg	Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32068
Registered No.

1. PLACE OF DEATH.
County of Twin Falls
City of Burley (No. , St.)

Registration District No. 39
Primary Registration District No. 2087

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ben H. Crisp

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Divorced

6. DATE OF BIRTH — — 1
(Month) (Day) (Year)

7. AGE 60 yrs. — mos. — ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Man
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ore.

10. NAME OF FATHER Don't Know

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER Nancy Bragg

13. BIRTHPLACE OF MOTHER (State or Country) Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wren Crisp
(Address)

15.
Filed 10-29 1920 J. H. Murphy
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Oct 27 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 26 1920, to Oct 27 1920
that I last saw him alive on Oct 27 1920
and that death occurred on the date stated above, at 11:30 AM
The CAUSE OF DEATH* was as follows:

Oedema of Lungs
2

(Duration) yrs. mos. ds.
Contributory (Secondary) Pneumonia Lobar
(Duration) yrs. mos. 9 ds.
(Signed) O. F. McClusky M. D.
10 29 1920 (Address) Burley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ REMOVAL Baker City Ore
DATE OF BURIAL ..... 191...

20. UNDERTAKER Homer B. Evans
ADDRESS Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

OREGON STATE BOARD OF HEALTH

CERTIFICATE OF DEATH

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

1 PLACE OF DEATH — State Registered No.....

County Twin Falls State..... Local Registered No.....

Township..... or Village..... or

City Buhl No....., ... St., ... Ward

(If death occurred in a hospital or institution, give its name instead of street and number)

2 FULL NAME Ben N. Crisp.

(a) Residence. No..... St., ...

(Usual place of abode) (If nonresident, give city or town and state)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Crisp.

6 DATE OF BIRTH (month, day, and year) May 25-1854

7 AGE Years	Months	Days	If less than 1 day, ... hrs. or ..... min.
66	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Sheep Man

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9 BIRTHPLACE (city or town) Yamhill (State or country) Oregon.

PARENTS

10 NAME OF FATHER Mansel A. Crisp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Nancy J. Beagel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky.

14 Informant Mrs. Crisp

(Address) Durkee Oregon.

15 Filed....., 19..... .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month day, and year) Oct 27 1920

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19....., that I last saw h..... alive on ....., 19....., and that death occurred on the date stated above, at ..... m.

The CAUSE OF DEATH * was as follows

Cerebral Hemorrhage

.....

.....

.....

.....(duration) ..... yrs., ... mos., ... days.

CONTRIBUTORY .....

(Secondary)

.....(duration) ..... yrs., ... mos., ... days.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death?..... Date of.....

Was there an autopsy?.....

What test confirmed diagnosis?.....

(Signed)....., M. D.

....., 19..... (Address) .....

* State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baker Ore.

DATE OF BURIAL 10/30 1920

20 UNDERTAKER

ADDRESS

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3 2 0 6 9 5

Registered No.

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH
County of Valley
City of Cascade
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6
Primary Registration District No. 6
(No. ....., ... St.)

2. FULL NAME Alecia Hurff

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Sept (Month) 17 (Day) 1880 (Year)

7. AGE: 40 yrs. 1 mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: Housekeeper
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Julian Friels

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Mary Lawson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G E Hoff
(Address) Cascade

15. Filed Nov 5 1920 J. L. Reynolds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920, to Nov 1 1920, that I last saw h alive on Nov 1 1920, and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis

(Duration) 4 yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G E Hoff M. D.

19..... (Address) Cascade

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Idaho — DATE OF BURIAL: 11/4 1920

20. UNDERTAKER: C. D. Bucknum — ADDRESS: Emmett Idaho

N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16172

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Lewis

City of Craigmont Idaho.

Registration District No. 50

Primary Registration District No. 2129

(No. ....., ... St.)

File No. 32070

Registered No. 16

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Werner S. Huber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	White	Married

6. DATE OF BIRTH.

Oct. 11 (Month) (Day) 1892. (Year)

7. AGE

27 Yrs. 10 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Oregon

10. NAME OF FATHER Jacob J. Huber

11. BIRTHPLACE OF FATHER Switzerland

(State or Country)

12. MAIDEN NAME OF MOTHER Elizabeth Mueller

13. BIRTHPLACE OF MOTHER

(State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ernest Huber

(Address) Craigmont Idaho

15.

Filed 9-7 1920 R. D. Dwight, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (4)

Sept. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 21 1920. to Sept. 4 1920., that I last saw him alive on Sept. 4 1920. and that death occured on the date stated above, at 9.15 P. M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

.....(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary)

.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) John J. Karlen M. D.

9/6 1920 (Address) Craigmont, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
I.O.O.F. Cemetery	9/8 1920

20. UNDERTAKER Star Furniture and Impl. Co.

ADDRESS Craigmont

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24858

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. V
Primary Registration District No. 1604
File No. 32071
Registered No. 381

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 818 N 10 St. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Felix Thomas Jones
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: November (Month) 20 (Day) 1893 (Year)

7. AGE: 26 Yrs. 11 Mos. 29 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Attorney at Law
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: T. J. Jones

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Winifred Cullen

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tom J. Jones Jr.
(Address) 818 N 10 St

15. Filed Nov 23 1920 R. H. Coate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1920, to Nov 19 1920, that I last saw h.i.m. alive on Nov 19 1920, and that death occurred on the date stated above, at 11.9. M.

The CAUSE OF DEATH* was as follows:
Exophthalmic goiter. Hypertrophy of heart.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Generally debilitated for 2 years.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. O. McCalla M. D.
11/20 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	Nov 24 1920
20. UNDERTAKER	**ADDRESS**
Schreiber & Hidenfeldt	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Boeck

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32072

Registered No. 4787

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. 510 N. 12 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Agnes Erickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct 22 1913 (Month) (Day) (Year)

7. AGE: 7 Yrs. 1 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Axel Erickson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Ingaliane

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Axel Ericksen

(Address) 510 N. 12 St Boise Idaho

15. Filed Dec 17 1920

P. H. Craig
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 16 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14th 1920 to Dec 16th 1920 that I last saw h... alive on Dec 16th 1920 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Carbuncle of the face following Diphtheria

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Diphtheria

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas Boeck M. D.

12-17 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 17 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM [illegible]

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH

Registration District No. 2

Primary Registration District No. 104

(No. 615 W. Spring Ave St.)

2. FULL NAME Robert P. Fraser

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32073

Registered No. 302

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: May (Month) 2 (Day) 1838 (Year)

7. AGE: Yrs. 82 Mos. 6 ds. 21

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Live Stock

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia

10. NAME OF FATHER: Robert Fraser

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Nancy McCloud

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert L. McAfee

(Address) Boise Idaho

15. Filed Nov 24 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 2 1920, to Nov 23 1920, that I last saw h[illegible] alive on Nov 22 1920 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Calvert M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 11/24 1920

20. UNDERTAKER: Schreiber & Siedenfaden — ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32074

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

(No. Reclamation Ave. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nellie Holmes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: July (Month) 25 (Day) 1837 (Year)

7. AGE: 83 Yrs. 4 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): North Carolina

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. Jones

(Address) N. P. R. R. Boise Idg

15. Filed Nov 26 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26th (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25th 1920 to Nov 26th 1920. that I last saw her alive on Nov 25th 1920. and that death occurred on the date stated above, at 6:30 AM

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the heart

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) Arterio-sclerosis

(Duration) 15 yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Nov 26-20 (Address) 515 Overland Bldg.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 27 1920

20. UNDERTAKER: Summers & Hicks — ADDRESS: Boise Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32075
Registered No. 384

1. PLACE OF DEATH
County of Ada,
City of Boise,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1904
(No. St. Lukes, Hospital, St.)

2. FULL NAME Mary M. Young.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov - 8 - 1867
(Month) (Day) (Year)

7. AGE: 53 Yrs. 0 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York.

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise Idaho.

15.
Filed Nov 27 1920 T. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 26 1920,
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1920, to Nov 26 1920, that I last saw h.er alive on Nov 25 1920, and that death occurred on the date stated above, at 2.4 M.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene of Right Leg.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Diabetes
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. W. Stigum M. D.
11/26 1920 (Address) Boise, Idaho,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. ~~LENGTH~~ OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11/28 1920

20. UNDERTAKER: Wm McBratney — ADDRESS: Boise, Idaho.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32676

Registered No. 385

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

(No. St. Alphonsus Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edmund Seward Phelps

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~ (Write the word.): Single

6. DATE OF BIRTH: November 10 1909 (Month) (Day) (Year)

7. AGE: 11 Yrs. 0 Mos. 16 ds.

If LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Ada Co, Ida.

10. NAME OF FATHER: Willard Phelps Jr.

11. BIRTHPLACE OF FATHER (State or Country): Minn.

12. MAIDEN NAME OF MOTHER: Elvira Woods.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm M. Bradley

(Address) Boise Idaho.

15. Filed Nov 27 1920 R. H. Coats Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21 1920, to Nov 26 1920, that I last saw h.. alive on Nov 26 1920, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus.

(Duration) 6 Yrs. mos. ds.

Contributory (Secondary) Chronic nephritis

(Duration) yrs. mos. 6 ds.

(Signed) M. D. Talleman M. D.

11/27 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill. DATE OF BURIAL: 11-28 1920

20. UNDERTAKER: Wm McBradley ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

Registration District No. 7
Primary Registration District No. 1004
File No. 32077
Registered No. 29

County of Ada.
City of Boise.
(No. 304 West Bannock. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary C. Prosser.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: June 21 (Month) (Day) 1864 (Year)

7. AGE: 56 Yrs. 5 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: James Raymond.

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Wade.

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Beatrice V. Prosser
(Address) Emerald, Wash.

15. Filed Nov 29 1920 R H Crate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 27 (Month) (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1920 to Nov 27 1920 that I last saw h..... alive on Nov 26 1920 and that death occurred on the date stated above, at 8:20 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia Pectoris

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Unknown

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James H Clement M. D.
11/29/20 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: Nov 29 1920

20. UNDERTAKER: Summers & Webb. — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32078

Registered No. 384

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

(No. 715 Washington St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Ella Hunt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. ~~SINGLE, MARRIED~~, WIDOWED ~~OR DIVORCED~~: Widowed (Write the word.)

6. DATE OF BIRTH: May (Month) 6 (Day) 1846 (Year)

7. AGE: 74 Yrs. 6 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bristol Co. Illinois

10. NAME OF FATHER: Francis Asbury Emmons

11. BIRTHPLACE OF FATHER (State or Country): New Jersey

12. MAIDEN NAME OF MOTHER: Lydia Ann Morris

13. BIRTHPLACE OF MOTHER (State or Country): New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Eva Hunt Dockery

(Address) 715 Washington St.

15. Filed NV 30 1920

R. H. Beale
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-29 1920 to 11/29 1920, that I last saw h-er alive on 11/29 1920, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Pettingill M. D.

11/30 1920 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Cremation Portland Ore. DATE OF BURIAL: 12/4 1920

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32079

Registered No.

1. PLACE OF DEATH

County of Ada.

City of Boise.

Registration District No. 1

Primary Registration District No. 4 of

(No. 1414 No 16th St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Caroline Buckner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	W.	Married

6. DATE OF BIRTH Jan. 6. 1852
(Month) (Day) (Year)

7. AGE 68 Yrs. 9 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Thomas. Bitton

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER (State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. McBratney

(Address) Boise Idaho.

15. Filed NOV 1 1920

R. H. Isaac
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 30 - 1920.
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 19 19, to Oct 29 19 20, that I last saw h.er alive on Oct 19 19 20, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Cause of Stomach

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O H Parker M. D.

10/30 19 20. (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	11/2 19 20.

20. UNDERTAKER W. McBratney

ADDRESS Boise, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32650

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1 ward

(No. St Lukes Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Isaac B. King.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: W (Write the word.)

6. DATE OF BIRTH: June 24 (Month) (Day) 1847 (Year)

7. AGE: 73 Yrs. 4 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: John King.

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Sharp

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. Shenk

(Address) Nampa Idaho.

15. Filed Nov 1 1920

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 28 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 22 1920, to Oct. 28 1920.

that I last saw h[illegible] alive on Oct. 28 1920,

and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Prostatectomy

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Earl Keel M. D.

10/29/20 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: La Hunta Colo

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Summers & Krebs.

ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32081
Registered No. 365

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1007

(No. 410 W. State St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alva Marion Vanderford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: May (Month) 28 (Day) 1882 (Year)

7. AGE: 38 Yrs. 5 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Marion F. Vanderford

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Caroline Keeling

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B J Vanderford

(Address) 0 Grandview

15. Filed Nov 1 1920 R. K. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 23 1920 to Oct. 30 1920 that I last saw h.. alive on Oct. 30 1920 and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Genual peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Ruptured appendix.

(Duration) ..... yrs. ..... mos. 10 ds.

(Signed) J. Carl Nies M. D.

11/1/20 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 1 1920

20. UNDERTAKER: Summers & Kuhn — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32082
Registered No. 3264

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 711 Idaho St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2
Primary Registration District No. 1004

2. FULL NAME Hop Ho

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Yellow
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: about 75 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Gardener
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charley Quong
(Address) Boise

15. Filed Nov 3 1920 R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ deceased ~~from~~ dead Nov. 2 - 1920 ~~19—~~, that I last saw h.m alive on Nov 1 1920 and that death occurred on the date stated above, at about 2 P.M.

The CAUSE OF DEATH* was as follows:
No doctor in attendance been sick about a week refused to have a doctor.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Charley Quong M. D.
19..... (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Chinese Cemetery | DATE OF BURIAL: 11/3 1920

20. UNDERTAKER: Schreiber & Sidenfaden | ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32083
Registered No. 567

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 410 State St.)

Registration District No. 7

Primary Registration District No. 1007

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Freda W. Hett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct. (Month) 31 (Day) 1920 (Year)

7. AGE: ....Yrs. ....Mos. 1 ds.

IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION

(a)* Trade, profession or particular kind of work: nurse

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Ida

10. NAME OF FATHER: Fred W. Hett

11. BIRTHPLACE OF FATHER (State or Country): Kas.

12. MAIDEN NAME OF MOTHER: Hazel Francis

13. BIRTHPLACE OF MOTHER (State or Country): Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elsie M. Francis

(Address) 818 State St.

15. Filed NOV 3 1920

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,

that I last saw h.. alive on ....19....,

and that death occurred on the date stated above, at ....M.

The CAUSE OF DEATH* was as follows:

Non Closure Foramen Ovale

Infundibular 22 hrs —

(Duration) ....Yrs. ....mos. ....ds.

Contributory (Secondary)

(Duration) ....yrs. ....mos. ....ds.

(Signed) Chas. V. Genoway M. D.

....19.... (Address) ....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hill City Cemetery	10/3 1920

20. UNDERTAKER	ADDRESS
Schreiber & Hedenfadt	Boise

Dr Genoway

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32084

Registered No. 771

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No.

(No. 1213 Grand Ave St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank E. Harrington

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 9 (Day) 1862 (Year)

7. AGE: 58 Yrs. — Mos. 25 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jefferson Co. Wis.

10. NAME OF FATHER: Hiram Harrington

11. BIRTHPLACE OF FATHER (State or Country): Am.

12. MAIDEN NAME OF MOTHER: Cynthia ?

13. BIRTHPLACE OF MOTHER (State or Country): Am.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Mertie Harrington

(Address)

15. Filed Nov 6 1920

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/3 10 p 1920, to 11/4/20 - 4 am 19, that I last saw him alive on 11/3 1920, and that death occurred on the date stated above, at 4 a M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) — Yrs. — mos. 6 ds.

Contributory (Secondary) Myocarditis

? (Duration) ? yrs. ? mos. ? ds.

(Signed) F W Ulmend M. D.

11/4 1920 (Address) Overland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11/7 1920

20. UNDERTAKER: Schreiber & Leidecker — ADDRESS: Boise Ida

Almona

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No.
File No. 32085
Registered No. 73

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410 N State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter C. Cleveland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Feb. (Month) 26 (Day) 1861 (Year)

7. AGE: 59 Yrs. 8 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Stockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Lowell Cleveland

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Anna Wakefield

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. W. C. Cleveland
(Address) 140 E. Bannock St.

15. Filed Nov 6 1920 — R. H. Coate, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Aortitis

(Duration) 9 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. W. Sorris M. D.
Nov 6 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov. 6 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 104
File No. 32686
Registered No. 373

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 110 East Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alfred Heyman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb. (Month) 26 (Day) 1872 (Year)

7. AGE: 48 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jackson Co. Kas

10. NAME OF FATHER: Chas Heyman

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Margt. Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louis E Heyman
(Address) 1415 E Jefferson St

15. Filed Nov 6 1920
G H Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1920 to Nov 4 1920
that I last saw him alive on Nov 3 1920
and that death occurred on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia Bronchial
(Duration) Yrs. mos. 20 ds.
Contributory (Secondary) Internal injuries in fall
(Duration) yrs. mos. ds.

(Signed) R E Shumway M. D.
Nov 5 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 11 9 1920
20. UNDERTAKER: Schneider & Siebenthaler — ADDRESS: Boise

Shumway & Fowler

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 32087
Registered No. 3744

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 1114 N 13. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha S. Thrailkill
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: June 13 (Month) (Day) 1838 (Year)

7. AGE: [redacted] Yrs. 4 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Henry Evans

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Harriet Veasey

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L.C. Thrailkill
(Address) 1114 N. 13th St. Boise

15. Filed Nov 12 1920
P.H. Arata
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Nov 12 1920
that I last saw her alive on Nov 11 1920
and that death occurred on the date stated above, at 7A M.
The CAUSE OF DEATH* was as follows:
Valvular Heart disease
(Duration) 6 Yrs. mos. ds.
Contributory (Secondary) Pulmonary Oedema
(Duration) yrs. mos. 2 ds.
(Signed) F. N. Bratton M. D.
Nov 12 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 13 1920
20. UNDERTAKER: Summers & Kirby — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Number

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

Registration District No. 4

Primary Registration District No. 1044

(No. 812 Brumback St.)

File No. 32088

Registered No. 77

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pearl E. Smith.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	White	Married (or widowed)

6. DATE OF BIRTH: Nov 9 (Month) 9 (Day) 1885 (Year)

7. AGE: 35 Yrs. — Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Elias Brackler.

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Mary —

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gilbert Smith
(Address) 812 Brumback St.

15. Filed NOV 12 1920

P. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 9 1920, to Nov 11 1920, that I last saw h.. alive on Sept 11 1920, and that death occurred on the date stated above, at 7:45 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno R Nuckols M. D.

11/12 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Nov 14 1920
20. UNDERTAKER	ADDRESS
Summers & Cobbs	Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 32089
Registered No. 376

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 410, State St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert A. Blakeman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: December 7 1886 (Month) (Day) (Year)

7. AGE: Yrs. 33 Mos. 11 ds. 13

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer): Owner

9. BIRTHPLACE (State or Country): California, Missouri

10. NAME OF FATHER: Henry E. Blakeman

11. BIRTHPLACE OF FATHER (State or Country): Connecticut

12. MAIDEN NAME OF MOTHER: Margaret G Bard

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. A. Blakeman

(Address) 65 Fairfield Ave Bridgeport Conn

15. Filed Nov 15 1920 R. H. Gale Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 15 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 15 1920, to Nov. 15 1920, that I last saw him alive on Nov. 15 1920, and that death occurred on the date stated above, at 12 15 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D O Hagg M. D.

11 15 1920 (Address) 602 Idaho St, Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. 2 mos. 6 days. In the State 10 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Idaho

Former or usual residence Idaho for 10 years

19. PLACE OF BURIAL OR REMOVAL: California Mo.

DATE OF BURIAL: Nov 16 1920

20. UNDERTAKER: Schreiber & Sidenfaden

ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32090
Registered No. 3777

Registration District No. 2
Primary Registration District No. 1004

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 411 Washington Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. W. Cruikshank
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: February 22 1851 (Month) (Day) (Year)

7. AGE: 69 Yrs. 8 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Logger
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nova Scotia Can.

10. NAME OF FATHER: Jas. Cruikshank

11. BIRTHPLACE OF FATHER (State or Country): Nova Scotia Can.

12. MAIDEN NAME OF MOTHER: Nancy McCarty

13. BIRTHPLACE OF MOTHER (State or Country): Nova Scotia Can

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Cruikshank
(Address) 1502 N 13 St

15. Filed Nov 16 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8 1920, to Nov 12 1920, that I last saw h.i.m. alive on Nov 12 1920, and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Lower end of Stomach

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. A. McCalla M. D.

11/12/1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Cabastan Ida.

19. PLACE OF BURIAL OR REMOVAL: Truro Nova Scotia Canada
DATE OF BURIAL 19.....

20. UNDERTAKER: Schreiber & Siebenfaden
ADDRESS: Boise Ida

Dr. McCalla.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32091

Registered No. 378

Registration District No. 7

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 615 N 8 St St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jannie Elizabeth Sherrill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Sept (Month) 11 (Day) 1848 (Year)

7. AGE: 72 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: George Tosh

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. A. Sherrill

(Address) Rose Shoe Bud Ida

15. Filed Nov 18 1920

P. L. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/2 1920, to 11/16 1920, that I last saw h.er alive on 11/16 1920 and that death occurred on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Kidney (R.)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Carcinoma Uteri

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. A. Tidey M. D.

11/17 1920 (Address) Owsley Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Nov 19 1920

20. UNDERTAKER: Summers & Krebs

ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8
Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32093
Registered No. 89

1. PLACE OF DEATH
County of Ada
City of Meridian
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virgil Troutt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Sept 29 1899 (Month) (Day) (Year)

7. AGE: 21 Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John. Trout.

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Nancy Easton

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M Bozon
(Address) Boise Rt 4 R Box 1

15. Filed Nov 2 1920 R. H. Coate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 1 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Nov 1 19 20 to ..... 19 ....., that I last saw h~~im~~ alive on Nov 1 19 20 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Accidently shot with shot Gun

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner
11/2 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandoval Ill. DATE OF BURIAL: Nov 6 1920

20. UNDERTAKER: Summers & Kirtley ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2044
File No. 32504
Registered No. 90

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George N. Everett.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Widower

6. DATE OF BIRTH
Nov 12 1848
(Month) (Day) (Year)

7. AGE
71 Yrs. 11 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Carpenter.
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE
(State or Country) Ohio.

10. NAME OF FATHER Clement Everett.

11. BIRTHPLACE OF FATHER
(State or Country) Maine.

12. MAIDEN NAME OF MOTHER Ophelia Meadwath.

13. BIRTHPLACE OF MOTHER
(State or Country) Connecticut.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Fayette Anderson
(Address) Boise Ida

15. Filed NOV 9 1920 R. H. Coats
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 6/1 1920 to 11/8 1920
that I last saw him alive on 11/6 1920
and that death occurred on the date stated above, at 4 A M.
The CAUSE OF DEATH* was as follows:

Carcinoma of face.

(Duration) 1 Yrs. 6 mos. ds.
Contributory (Secondary) Hemorrhage
(Duration) yrs. mos. ds.

(Signed) H. H. Tuttle M. D.
11/9 1920 (Address) Oakland Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cem. DATE OF BURIAL Nov. 10 1920,

20. UNDERTAKER Summers & Gebs. ADDRESS Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
File No. 32095
Registered No. 91

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 6 Miles west of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilhelmina Wozniak

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Sept. 28 (Month) (Day) 1826 (Year)

7. AGE: 94 Yrs. 1 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Poland

10. NAME OF FATHER: Matt Z

11. BIRTHPLACE OF FATHER (State or Country): Poland

12. MAIDEN NAME OF MOTHER: Modoblonowska

13. BIRTHPLACE OF MOTHER (State or Country): Poland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Antony Wozniak
(Address) Boise Idaho

15.
Filed Nov 13 1920
R H Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Nov 8 1920, that I last saw h[illegible] alive on Nov 7 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Cerebral apoplexy

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Arterio sclerosis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) D P Higgs M. D.

11-11 1920 (Address) 1622 Warm St Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Johns Cemetery	Nov. 12 1920

20. UNDERTAKER	ADDRESS
Schreiber & Sieberden	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32096
Registered No. 92

Registration District No. 8
Primary Registration District No. 2004

1. PLACE OF DEATH
County of Ada
City of Near Boise (No.) Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: (Month) (Day) 1844 (Year)

7. AGE: 76 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Idaho

15. Filed Nov 20 1920 — P. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9 1920 to Nov. 19 1920
that I last saw him alive on Nov. 19 1920
and that death occurred on the date stated above, at 10 PM.

The CAUSE OF DEATH* was as follows:
Hemoplegia due to arterio - sclerosis
(Duration) ... Yrs. ... mos. 10 ds.
Contributory (Secondary) Senility
(Duration) ... yrs. ... mos. ... ds.

(Signed) Roscoe C. Ward M. D.
11/20 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Nov 24 1920
20. UNDERTAKER: Summers & Keck — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No.
(No. , St.)
File No. 32097
Registered No.

1. PLACE OF DEATH
County of Ada
City of
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kobe Wataki

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M Yellow
4. COLOR OR RACE
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: March 1 (Month) (Day) 1884 (Year)

7. AGE: 36 Yrs. 8 Mos. 16 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Section Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: Kidakachi Wataki

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. Yasuda
(Address) 1019 Main Boise

15. Filed Nov 20 19 20 W. C. Murphy Local Registrar / State

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) – 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Nov-17 1920 to 19..... that I last saw him ~~alive~~ on dead Nov 17 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suicide Gun shot wound

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner M. D.
11/20 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Japanese Cemetery — DATE OF BURIAL: Nov 20 1920
20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No.
File No. 32098
Registered No.

1. PLACE OF DEATH
County of Ada
City of Eagle
(No. near Brookside School St.)
If death occurred away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Halley Vincen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: Mar 11th 1844 (Month) (Day) (Year)

7. AGE: 76 Yrs. 8 Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ills.

10. NAME OF FATHER: Halley Vincen

11. BIRTHPLACE OF FATHER (State or Country): Am

12. MAIDEN NAME OF MOTHER: Eagleson

13. BIRTHPLACE OF MOTHER (State or Country): Am

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs D E Clemmens
(Address) Dry Creek

15. Filed Dec 7 1920 Fredric K Lewis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 5th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920 to DEC. 5 1920, that I last saw him alive on DEC. 3 1920, and that death occurred on the date stated above, at 4 40 P.M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Fracture of hip
(Duration) 1 yrs. ..... mos. ..... ds.
(Signed) L L Bowers M. D.
1920 (Address) 303 N. 12 st

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ada County, Idaho.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Dry Creek Cemetery	12/8 1920
20. UNDERTAKER	ADDRESS
Schreiber & Siddenfaden	Boise, Idaho

Dr. Bowers

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No.
File No. 32099
Registered No.

1. PLACE OF DEATH
County of Ada
City of Star
(No. Star St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel L Barker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX M.
4. COLOR OR RACE White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Married
6. DATE OF BIRTH Feb 18 1859 (Month) (Day) (Year)
7. AGE 61 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country) Cass Co. Neb.
10. NAME OF FATHER Saml Barker
11. BIRTHPLACE OF FATHER (State or Country) England
12. MAIDEN NAME OF MOTHER Lydia Wood
13. BIRTHPLACE OF MOTHER (State or Country) Mo
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. E. E. Barker
(Address) Star. Idaho.
15. Filed Nov 30 1920 Fardrin K Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 28 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from , 19 , to Nov 28 1920, that I last saw him alive on Nov 25 1920, and that death occurred on the date stated above, at 11 P.M.
THE CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) 4 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) C W Hall M. D.
11/28 1920 (Address) Star Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Star. Idaho

19. PLACE OF BURIAL OR REMOVAL Harris Hill Cemetery — DATE OF BURIAL 12/1 1920
20. UNDERTAKER Schreiber & Sidenfaden — ADDRESS Boise. Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No. 11
File No. 32100
Registered No. 3

1. PLACE OF DEATH
County of Ada
City of Meridian
(No. 253 [illegible] St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gertrude M Bishir

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 13 (Day) 1906 (Year)

7. AGE: 14 Yrs. [illegible] Mos. 6 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: school girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rock Creek Montana

10. NAME OF FATHER: Ralph H Bishir

11. BIRTHPLACE OF FATHER (State or Country): Livingston Montana

12. MAIDEN NAME OF MOTHER: Rose A. Hall

13. BIRTHPLACE OF MOTHER (State or Country): Scranton Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Rose V. Bishir
(Address) Meridian Idaho

15. Filed Dec 3 1920 H.F. Mead Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23 1920, to Dec. 2 1920 that I last saw h[illegible] alive on Nov. 23 1920. and that death occurred on the date stated above, at 10:30 M.

The CAUSE OF DEATH* was as follows: Tuberculosis meningitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H F Mead M. D.

Dec 3 1920 (Address) Meridian

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death..... yrs. ..... mos. ..... days. In the State..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Meridian | DATE OF BURIAL: Dec 5 1920

20. UNDERTAKER: W P Mahon | ADDRESS: Meridian

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of **Gertrude M. Bishir**

now lying buried in **Meridian** Cemetery, in the City or Town of **Meridian**

County of **Ada** State of Idaho, who died on the **2** day of **December**, 1920, Aged ____ years ____ months

____ days, the cause of death being **Mitral Lesion with dilate** and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

N. F. Neal, M.D. attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by **Private** private or railway conveyance

to **Livingston City** Cemetery in the City or Town of **Livingston** County of —

State of **Montana** to take effect upon the approval by the local board of health of the City, Town, or County of

Ada it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this **22** day of **May**, A.D. 19**68**.

Permit issued to:

Geo Jerread
Chapel of the Chimes
Meridian, Idaho

W. W. Benson
by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of ____ State of Idaho, this ____ day of ____, 19__.

Health Officer

FORM BH 56-019

FORM V. S. No. 5-A—25 M. 1-19.

[redacted] RTIFICATE [redacted] EATH 32101

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. [redacted] 24

Primary Registration District No. 2202

File No. 1

County of Ada

City of 3 M. West Kuna (No. ..... St.)

Registered No. 28

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maurice Houdashelt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ✓

6. DATE OF BIRTH: May (Month) 14 (Day) 1919 (Year)

7. AGE: Yrs. 20 Mos. ..... ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Ed. Houdashelt

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Bertha Price

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ed Houdashelt

(Address) Kuna Ida

15. Filed Nov. 25 1920 R M Bowell Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8:30 A.M. Nov. 18 1920 8 P.M. to Nov. 18 1920 that I last saw him alive on Nov 18 1920 and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Convulsions

(Duration) 3 hrs. ..... mos. ..... ds.

(Signed) R M Bowell M. D.

Nov. 19 1920 (Address) Kuna Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kuna Cem — DATE OF BURIAL: 11-20-1920

20. UNDERTAKER: Fred F Robinson — ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Adams

City of Indian Valley

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 32102

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sophia M Cox

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Apr (Month) 7 (Day) 1850 (Year)

7. AGE: 70 Yrs. 6 Mos. 2 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: W Selock

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Bofrey

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) x W H Cox

(Address)

15. Filed 11/20/20 19 R M Peterman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8/9/1920, to 10/9/1920, that I last saw h ex alive on 9/9/1920, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:

Cancer of Eye

Don't Know

(Duration) Yrs. mos. ds.

Contributory (Secondary) Valvular Heart disease

Don't Know.

(Duration) yrs. mos. ds.

(Signed) C A Wiseman M. D.

10/9 1920 (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Valley — DATE OF BURIAL: Oct 10 1920

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32103

Registered No.

1. PLACE OF DEATH

County of Adams

City of Indian Valley (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

2. FULL NAME Robert M Hamrick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: Dec (Month) 12 (Day) 1871 (Year)

7. AGE: 48 Yrs. 9 Mos. 25 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Steven Hamrick

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Margaretta Moore

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elvin Leichliter

(Address) Indian Valley

15. Filed 11/20/20 19.. W. M. Coleman Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 2 1920, to Oct. 1— 1920; that I last saw him alive on Oct. 1— 1920; and that death occurred on the date stated above, at 7:00 A.M.

The CAUSE OF DEATH* was as follows:

Inoperable Carcinoma - Cervical glands - right side —

(Duration) Yrs. 8 mos. — ds.

Contributory (Secondary) Senility - Exhaustion.

(Duration) yrs. mos. ds.

(Signed) W. M. Coleman Jr. M. D.

19.. (Address) Cambridge Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Valley — DATE OF BURIAL: Oct 8 1920

20. UNDERTAKER: J. A. Anderson — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32104

Registered No.

1. PLACE OF DEATH

County of Adams

City of Council

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Luther Franklin Palmer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: May (Month) 2 (Day) 1848 (Year)

7. AGE: 72 Yrs. 4 Mos. 1 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Thomas Palmer

11. BIRTHPLACE OF FATHER (State or Country): Miss (?)

12. MAIDEN NAME OF MOTHER: Abegail Austin

13. BIRTHPLACE OF MOTHER (State or Country): Miss (?)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15. Filed Sept 30 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23 1920, to Sept 3 1920, that I last saw h... alive on ...19..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:

Diseases of Kidneys

(Duration) 7 Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W M Brown M. D.

19... (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser

DATE OF BURIAL: 5 1920

20. UNDERTAKER: Young

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32106
Registered No.

Registration District No.
Primary Registration District No.

1. PLACE OF DEATH
County of Adams
City of Council
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James G. Button

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: April 4 1869 (Month) (Day) (Year)

7. AGE: 57 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Millman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~Ida~~ N.Y.

10. NAME OF FATHER: Ruben M. Button

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Abbie M. Utter

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Button Brother
(Address)

15. Filed Sept 1 20 1920 W M Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 10 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 19 , to Sept 10 19 , that I last saw h.m alive on Aug 20 1920 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:
Appendicitis & peritonitis
(Duration) Yrs. mos. 9 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W M W Brown M. D.
Sept 8 1920 (Address) Council

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cem
DATE OF BURIAL: Sept 11 1920

20. UNDERTAKER: Young
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32107
Registered No.

1. PLACE OF DEATH
County of Adams
City of Council
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Fred Hancock

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	married

6. DATE OF BIRTH August 21 (Month) 1873 (Day) (Year)

7. AGE Yrs. 26 Mos. 6 ds. 7
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer) Clerk in Store

9. BIRTHPLACE (State or Country) Council Adam Co Idaho

10. NAME OF FATHER John Hancock

11. BIRTHPLACE OF FATHER (State or Country) Green Co Ky

12. MAIDEN NAME OF MOTHER Josephine Underwood

13. BIRTHPLACE OF MOTHER (State or Country) Indian Valley Adams Co Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Hancock
(Address) Council Idaho

15. Filed Sept 30 1920 W M Brown Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH July (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 28 1920, to July 6 1920, that I last saw h.... alive on July 6 1920, and that death occurred on the date stated above, at 5 A. M.
The CAUSE OF DEATH* was as follows:
Brights Disease

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W M Brown M. D.
Sept 30 1920 (Address) Council

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Center Cemetery | DATE OF BURIAL July 8 1920

20. UNDERTAKER Young | ADDRESS Council

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32108

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 216
File No. 36
Registered No. 3447

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 517 N. 4th ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME H. C. Evans

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word)
Male	Colored	Married

6. DATE OF BIRTH Not Known
(Month) (Day) (Year)

7. AGE about 51 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work minister of
(b) General nature of industry, business or establishment in which employed (or employer) Colored Baptist

9. BIRTHPLACE (State or Country) Alabama

10. NAME OF FATHER Not Known

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs A. W. Peterson
(Address) 517 N. 4th ave Pocatello

15. Filed Nov 2 1920 J. P. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October 31 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 30 1920 to Oct. 31 1920 that I last saw h— alive on Oct. 31 1920. and that death occurred on the date stated above, at 11 20 A. M.

The CAUSE OF DEATH* was as follows: Intestinal perforation

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

11/2 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death — yrs. 2 mos. days. In the State — yrs. 3 mos. — days

Where was disease contracted if not at place of death?

Former or usual residence Los Angeles Cal.

19. PLACE OF BURIAL OR REMOVAL Losangeles Cal. | DATE OF BURIAL 19

20. UNDERTAKER McFarland Undertaking Co Pocatello Ida. | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A--25 M. 1-19.

CERTIFICATE OF DEATH

28 32109

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No. 28

Primary Registration District No. 2161

(No.) St. St. Anthony Hospital

File No. 36

Registered No. 3445

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Ann Gallet

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH Feb 12 (Month) (Day) 1836 (Year)

7. AGE 84 Yrs. 8 Mos. 21 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Kentucky

10. NAME OF FATHER Benedict B Gillispie

11. BIRTHPLACE OF FATHER (State or Country) Maryland

12. MAIDEN NAME OF MOTHER Eleanor a Dansberry

13. BIRTHPLACE OF MOTHER (State or Country) Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J B Gallet
(Address) Pocatello Idaho

15. Filed 11/4 1920 J H Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November (Month) 3rd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25th 1920, to Nov. 3rd 1920, that I last saw her alive on Nov. 3rd 1920, and that death occurred on the date stated above, at 4 00 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) Arterio-Sclerosis

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) W. G. Wright M. D.

11/4 1920 (Address) Pocatello, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View | DATE OF BURIAL 11-5 1920

20. UNDERTAKER Schumacher Bros | ADDRESS City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

32110

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 3161

(No. ... St.) Lynn Grove Hospital

File No. 34

Registered No. 3446

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Deede

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the Word.): Single

6. DATE OF BIRTH: Sept (Month) 24 (Day) 1854 (Year)

7. AGE: 56 Yrs. 1 Mos. 10 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): ...

9. BIRTHPLACE (State or Country): Louisiana

10. NAME OF FATHER: John L. Deede

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary C Seamore

13. BIRTHPLACE OF MOTHER (State or Country): California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos M Deeds

(Address) Caldwell Ida.

15. Filed 11/5 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 3 (Day) 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1920, to Nov 3 1920, that I last saw him alive on Nov 3 1920, and that death occurred on the date stated above, at 11-P M.

The CAUSE OF DEATH* was as follows:

Perineal abcess following primary infiltration

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Strychnine poisoning

(Duration) ... yrs. ... mos. ... ds.

(Signed) Dr Lynn M. D.

Nov 4 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted, if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL: Mt Cecil Cemetary — DATE OF BURIAL: 11/6 1920

20. UNDERTAKER: T. A. Walker — ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

32111

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 34
Registered No. 3447

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. County Dufurnary St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Pinkridge
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Colored
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Exact date unknown (Month) (Day) 1900 (Year)

7. AGE: 20 Yrs. Mos. ds. Years as known
IF LESS than 1 day how many hrs. min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: unknown
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): unknown

10. NAME OF FATHER: unknown

11. BIRTHPLACE OF FATHER (State or Country): unknown

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Lennie
(Address) County Dufurnary

15. Filed 11/8 1920 J. R. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1920 to Nov 7 1920
that I last saw h. alive on Nov. 7 1920,
and that death occurred on the date stated above, at 6 a M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
(Meningeal)
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. S. Wallace M. D.
Nov 8 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: mountain view — DATE OF BURIAL: Nov 8 1920

20. UNDERTAKER: Schumacher Hall — ADDRESS: city

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

32112

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 34
Registered No. 3448

1. PLACE OF DEATH

County of Bannock
City of McCammon
(No. Davidson St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jarad Green Sr

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH: April (Month) 10 (Day) 1856 (Year)

7. AGE: 64 Yrs. 6 Mos. 29 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cokeville Utah

10. NAME OF FATHER: Thomas Green

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Ann Elast

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Jarad Green Sr
(Address): McCammon

15. Filed Nov 9 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1920, to Nov 7th 1920
that I last saw h[illegible] alive on Nov 7th 1920
and that death occurred on the date stated above, at 11:20 P.M.

The CAUSE OF DEATH* was as follows:
Diabetes Mellitus
(Duration) Yrs. mos. ds.
Contributory (Secondary) Arteriosclerosis
(Duration) yrs. mos. ds.

(Signed) Wilson J McDell M. D.
Nov 9 1920 (Address) McCammon Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
McCammon Ida	Nov 9 1920
20. UNDERTAKER	ADDRESS
Schumacher & Hall	McCammon

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32113

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 244
File No. 36
Registered No. 3449

1. PLACE OF DEATH

County of Bannock
City of POCATELLO, IDAHO
(No. St Anthonys Hosp.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cornelius Henry Wall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: Nov 21 1876 (Month) (Day) (Year)

7. AGE: 44 Yrs. 7 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska.

10. NAME OF FATHER: Cornelius Wall

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacob H. Wall.
(Address) Minnedoka Ida.

15. Filed Nov 11. 1920 — J. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 11th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1920, to Nov 11 1920 that I last saw h[illegible] alive on Nov 10 1920, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Toxaemia following infection of right kidney and bladder

(Duration) ..... Yrs. 1 mos. 10 ds.

Contributory (Secondary) Myocarditis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) A M Newton M. D.

Nov 11 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death — yrs. — mos. 13 days. In the State 5 yrs. — mos. — days

Where was disease contracted if not at place of death?

Former or usual residence Minnedoka, Idaho,

19. PLACE OF BURIAL OR REMOVAL: Minnedoka Idaho — DATE OF BURIAL: Nov 11 1920

20. UNDERTAKER: H. L. McHAN — ADDRESS: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 32114

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 36
Registered No. 3450

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. St Anthonys Hosp)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benji Akagi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	Japanese	Married

6. DATE OF BIRTH: July (Month) 14 (Day) 1875 (Year)

7. AGE: 45 Yrs. 4 Mos. 2 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Japan

10. NAME OF FATHER: Tomajiro Akagi

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Japan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tsuisa Akagi
(Address) POCATELLO, IDAHO

15. Filed Nov 16 1920 — J. R. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1920, to Nov 16 1920, that I last saw h~~im~~ alive on Nov 15 1920, and that death occurred on the date stated above, at 12 00 A.M.

The CAUSE OF DEATH* was as follows:
Encephalatis

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Asa. Newton M. D.
Nov 16 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 9 days. In the State 21 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Japan Reservation

19. PLACE OF ~~BURIAL OR~~ REMOVAL: Portland Oregon — DATE OF BURIAL: Nov 17 1920

20. UNDERTAKER: H. L. McHAN — ADDRESS: POCATELLO, IDAHO

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32115

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 216
File No. 36
Registered No. 3451

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 224 So 8th ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nance Von Pool
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: April (Month) 14 (Day) 1879 (Year)

7. AGE: 43 Yrs. 7 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Roan Von Pool

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Nancy Markham

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L B Bacon
(Address) 224 So 8 ave Pocatello

15.
Filed Nov 16 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to Nov 16 1920, that I last saw h.er alive on Nov 16 1920 and that death occurred on the date stated above, at 1.45 P. M.
The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) A M Newton M. D.
Nov 16 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 5 yrs. mos. days. In the State 5 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence Boise Ida

19. PLACE OF BURIAL OR REMOVAL ~~Portland Oregon~~ DATE OF BURIAL Nov 18 1920

20. UNDERTAKER H. L. McClain ADDRESS Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

28 32116

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fremont
City of Grand Lake
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2161
(No. ....., ... St.)

File No. 34
Registered No. 3452
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mollie Merrill

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Oct. 26 (Month) (Day) 1896 (Year)

7. AGE: 24 yrs. — mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): Homestead duties

9. BIRTHPLACE (State or Country): Blackfoot Idaho

10. NAME OF FATHER: Jos Quigley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Virginia White

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Harold Quigley
(Address): Grand Lake Colo

15.
Filed Nov 17 1920 J. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1920 to Nov 10 1920 that I last saw her alive on Nov 8 1920 and that death occurred on the date stated above, at 8 M.

The CAUSE OF DEATH* was as follows:
Puerperal Sepsis and acute ilims

(Duration) ..... yrs. ..... mos. 4 ds.

Contributory (Secondary): Miscarriage
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) C. R. Cutler M. D.
Nov 11 1920 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs ....mos ....days. In the State ....yrs ....mos ....days.
Where was disease contracted if not at place of death?
Former or usual residence

PLACE OF BURIAL OR REMOVAL: Richmond Ut
DATE OF BURIAL: Nov 14 1920

20. UNDERTAKER: [illegible]
ADDRESS: Logan

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32117

28

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36

Registered No. 3453

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No. 2141

(No. 336 W. Clark St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Annita Landreth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word): Single

6. DATE OF BIRTH: Jan 30 (Month) (Day) 1920 (Year)

7. AGE: — Yrs. 9 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Portland Oregon

10. NAME OF FATHER: Al Landreth

11. BIRTHPLACE OF FATHER (State or Country): Colorado.

12. MAIDEN NAME OF MOTHER: Carrie Gonner

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Al Landreth

(Address) 336 W. Clark

15. Filed Nov 20 1920

J. F. Mooney
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 20 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19 1920, to Nov. 19 1920, that I last saw her alive on Nov. 19 1920, and that death occurred on the date stated above, at 2. A. M.

The CAUSE OF DEATH* was as follows:

Malnutrition

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) Acute Nodes or Convulsions

(Duration) ..... yrs. 3 mos. ..... ds.

(Signed) D. McGregor M. D.

11 Dec 1920, (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. 1 mos. — days. In the State ..... yrs. 1 mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence Portland Oregon

19. PLACE OF BURIAL OR REMOVAL: Mt View Pocatello | DATE OF BURIAL: Nov 21 1920

20. UNDERTAKER: H. L. McKean | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that if may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

28 32118

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 36

Registered No. 3454

1. PLACE OF DEATH

County of Bannock

City of Pocatello

Registration District No.

Primary Registration District No. 261

(No. 920 No Lincoln St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marion Marler Martindale

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Infant

6. DATE OF BIRTH: November 5 (Month) (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 15 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello

10. NAME OF FATHER: Marion C. Martindale

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Sarah E. Marler

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Marion C Martindale

(Address) 920 - No Lincoln

15. Filed 11/21 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 20 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1920 to Nov 17 1920

that I last saw him alive on Nov 17 1920

and that death occurred on the date stated above, at about noon M.

The CAUSE OF DEATH* was as follows:

Atelectasis Pulmonum

(Duration) ..... Yrs. ..... mos. 15 ds.

Contributory (Secondary) Premature birth

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) W W Brothers M. D.

Nov 21 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View	Nov 24 1920

20. UNDERTAKER	ADDRESS
Schumacher & Hull	Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32119

Registration District No. 28

Primary Registration District No. 2141

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34

Registered No. 3455

1. PLACE OF DEATH

County of Bannock

City of POCATELLO, IDAHO

(No. 546 N. Hayes St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Allen B. Dillrance

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Sept (Month) 20 (Day) 1865 (Year)

7. AGE: 55 Yrs. 2 Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Employee of RR.

(b) General nature of industry, business or establishment in which employed (or employer): Shops. Watchman

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John W. Dillrance

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Sophia S. Potter

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fanny D Coats

(Address) 546 N. Hayes St.

15. Filed Nov 22 1920

J. H. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 24 1920, to Nov. 20 1920, that I last saw him alive on Nov. 20 1920, and that death occurred on the date stated above, at 4.50 P.M.

The CAUSE OF DEATH* was as follows:

Sclerosis Coronary arteries
myocarditis.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) General arterio-sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Gregson M. D.

Nov 1920 (Address) Pocatello, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 14 yrs. ..... mos. ..... days. In the State 14 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or ~~usual residence~~ Nebraska

19. PLACE OF BURIAL OR REMOVAL: Mozaketa, Iowa — DATE OF BURIAL: Nov 23 1920

20. UNDERTAKER: H. L. McHAN — ADDRESS: POCATELLO, IDAHO

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32120

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 36
Registered No. 3456

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. Prudence St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse Argent Bateman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: February 12 1 (Month) (Day) (Year)

7. AGE: 50 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Freight Loss Clerk
(b) General nature of industry, business or establishment in which employed (or employer): ~~railroad~~

9. BIRTHPLACE (State or Country): West Jordon Utah

10. NAME OF FATHER: James Bateman

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Emmily Argent

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss J.A. Bateman
(Address) 15 Jefferson Ave

15. Filed Nov 24 1920 P Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 22 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-22 1920, to 11-22 1920, that I last saw h[illegible] alive on 11-22 1920, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris

(Duration) ..... Yrs. ..... mos. few hours ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D C Ray M. D.
11/24 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View Cem. DATE OF BURIAL: Nov 24 1920

20. UNDERTAKER: Schumacher & Hall ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

32121

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 86
Registered No. 3458

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Gasser
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Nov (Month) 23 (Day) 1920 (Year)

7. AGE: 2 hours old ds.
IF LESS than 1 day how many 2 hrs. or — min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello Idaho

10. NAME OF FATHER: Ivan Gasser

11. BIRTHPLACE OF FATHER (State or Country): Pocatello Idaho

12. MAIDEN NAME OF MOTHER: Lucille Edwards

13. BIRTHPLACE OF MOTHER (State or Country): Pocatello Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ivan Gasser
(Address) 132 So Hayes. Pocatello

15. Filed Nov 24 1920 J. R. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11- 19..., to 11- 19...,
that I last saw h... alive on ... 19...,
and that death occurred on the date stated above, at ... M.
The CAUSE OF DEATH* was as follows:

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
19... (Address) ...

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? Same
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem — DATE OF BURIAL: Nov 24 19 20

20. UNDERTAKER: H. L. McHan — ADDRESS: Pocatello.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH 32122

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 34
Registered No. 3457

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John H. Singer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: February (Month) 20 (Day) 1840 (Year)

7. AGE: 80 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: John Singer

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Russell Fahlstrom
(Address) R. F. D. #1

15. Filed 11/24 1920
J. R. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from N. 15 1920 to 1920
that I last saw h..... alive on N. 8 1920
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

11 19 20 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View [illegible]
DATE OF BURIAL: Nov 24 1920

20. UNDERTAKER: Schumacher & Hall
ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32123

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 36
Registered No. 3459

1. PLACE OF DEATH
County of Bannock
City of Pocatello (No. Pocatello General Hos St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Cutler
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.): Single

6. DATE OF BIRTH: Nov (Month) 23 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. — ds.
IF LESS than 1 day how many 4 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello, Ida

10. NAME OF FATHER: Joseph Cutler

11. BIRTHPLACE OF FATHER (State or Country): Pocatello Idaho

12. MAIDEN NAME OF MOTHER: Rosella Ball

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph S. Cutler
(Address) 835½ N. Hanson

15. Filed Nov 24 1920 J. Young, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1920, to ... 19..., that I last saw h[er] alive on Nov 23 1920, and that death occurred on the date stated above, at 2:30 A. M.
The CAUSE OF DEATH* was as follows:
Immature (abortion)
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Toxaemia of Pregnancy
(Duration) ... yrs. ... mos. ... ds.
(Signed) Hamner Cluni M. D.
11/24 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? Life
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View Cem. DATE OF BURIAL: Nov 24 1920

20. UNDERTAKER: H. L. McHan ADDRESS: Pocatello Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

32124

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 36
Registered No. 3460

1. PLACE OF DEATH
County of Bannock
City of McCammon (No. [illegible] Lead St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Frazee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: April (Month) 1 (Day) 1890 (Year)

7. AGE: 29 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rd Brakeman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Weir City Kansas

10. NAME OF FATHER: Paul Frazee

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. L. Brown
(Address) Pocatello Ida

15. Filed 11/25 19 20
J. Young
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 1. P. M.
The CAUSE OF DEATH* was as follows:

Accidental death
Rd accident

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S S Ferguson M. D.
11-24 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Edmonton Cem
DATE OF BURIAL: 11 26 1920

20. UNDERTAKER: W. D. Parker
ADDRESS: Pocatello Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

32125

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock Registration District No. 28

City of Pocatello (No.) St. Anthony Hospital Primary Registration District No. 2161 File No. 36

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lewis E. Rodebach Registered No. 3461

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Single

6. DATE OF BIRTH: June (Month) 6 (Day) 1913 (Year)

7. AGE: 7 Yrs. 5 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lester B. Rodebach

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mam E. Lewis

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lester B. Rodebach
(Address) 518 N. 8 st.

15. Filed 11/26/ 1920 J. P. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9 1920, to Nov. 23 1920, that I last saw h.. alive on Nov 23 1920, and that death occurred on the date stated above, at 11.30 p M.
The CAUSE OF DEATH* was as follows:

Pneumonia
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) J. M. Sprague M. D.
11-26 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mountain View	Nov 26 1920
20. UNDERTAKER	ADDRESS
Schumacher Bros	City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32126

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 36
Registered No. 3462

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME. Joseph Clay Oliver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August 23 1895 (Month) (Day) (Year)

7. AGE: 25 Yrs. 3 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business or establishment in which employed (or employer): O.S.L. R.R.

9. BIRTHPLACE (State or Country): Pocatello Ida.

10. NAME OF FATHER: J Thomas Oliver

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Clay Ann Elizabeth

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas Oliver

(Address) Pocatello.

15. Filed 11/29 1920. J R Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 27 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7. 1920 to Nov. 27 1920 that I last saw h[e] alive on Nov. 27 1920 and that death occurred on the date stated above, at 5.30 P.M.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus

(Duration) ... Yrs. ... mos. 3 ds.

Contributory (Secondary) Multiple perforations of small bowel

(Duration) ... yrs. ... mos. 20 ds.

(Signed) F. R. Peterson M. D.

11/27 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Nov 30 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock

City of Bancroft

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 84

Primary Registration District No. 2161

(No. ..... St.)

File No. 32157

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Richards Gummersall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH: August 25th, 1919. (Month) (Day) 1 (Year)

7. AGE: Yrs. 15 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: infant
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Turner Idaho.

10. NAME OF FATHER: George H. Gummersall

11. BIRTHPLACE OF FATHER (State or Country): Franklin Idaho.

12. MAIDEN NAME OF MOTHER: Alda McClellan

13. BIRTHPLACE OF MOTHER (State or Country): Mexico.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) (Sgn.) George H. Gummersall
(Address) Bancroft Idaho.

15. Filed ..... 19 .....

O. H. Lundt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 25th, 1920. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 25th 1920, to Nov. 25th 1920, that I last saw h. im alive on Nov. 25 1920, and that death occurred on the date stated above, at 5.30 a M.

The CAUSE OF DEATH* was as follows:
Acute suppurative tonsilitis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) broncho-penumonia

(Duration) ..... Yrs. ..... mos. 1 ds.

(Signed) Oscar V. Linhardt M. D.

Nov. 25 1920 (Address) Bancroft Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Turner Idaho.
DATE OF BURIAL: Nov. 27 1920

20. UNDERTAKER: father
ADDRESS: Bancroft Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 54
Primary Registration District No. 2161
File No. 32128
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Bancroft
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Matthews

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	W	single

6. DATE OF BIRTH Oct. 24 1920
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 1 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bancroft.

10. NAME OF FATHER Michael Tully

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Minnie

13. BIRTHPLACE OF MOTHER (State or Country) Rawlins Wyo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) father —
(Address) Bancroft

15. Filed ..... 19.....
O Whitehurst
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920 to Oct 24 1920
that I last saw h. alive on Oct 24 1920
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Premature birth
(Duration) ..... yrs. ..... mos. 1 ds.
(Signed) O Whitehurst M. D.
Oct 24 1920 (Address) Bancroft Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Bancroft — DATE OF BURIAL Oct 25 1920

20. UNDERTAKER father — ADDRESS Bancroft

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 84
Primary Registration District No. 2161
File No. 32129
Registered No.

1. PLACE OF DEATH
County of Bannock
City of Bancroft.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillbrow.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	single

6. DATE OF BIRTH
Nov. (Month) 12 (Day) 1920 (Year)

7. AGE
..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 1 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Bancroft Idaho.

10. NAME OF FATHER Edward K. Rankin

11. BIRTHPLACE OF FATHER (State or Country) Colden Ill.

12. MAIDEN NAME OF MOTHER Myrtle M. Jones

13. BIRTHPLACE OF MOTHER (State or Country) McKinney Co. Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) father
(Address) Bancroft.

15. Filed ..... 19.....
O. H. Church
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1920, to Nov 12 1920, that I last saw h.. alive on Nov 12 1920, and that death occurred on the date stated above, at 8:30 P.M.
The CAUSE OF DEATH* was as follows:

Miscarriage

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) premature birth
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) O. H. Church M. D.
19..... (Address) Bancroft Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Bancroft — DATE OF BURIAL Nov 12 1920

20. UNDERTAKER father — ADDRESS Bancroft.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 31
Primary Registration District No.
File No. 132130
Registered No. 26

1. PLACE OF DEATH
County of Benewah
City of Idaho
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn Brede.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W	

6. DATE OF BIRTH
11 (Month) 1 (Day) 1920 (Year)

7. AGE
XX Yrs. XX Mos. XX ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Benewa Co Idaho

10. NAME OF FATHER George Brede

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Emma Osthella

13. BIRTHPLACE OF MOTHER (State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Bredl
(Address) Tekoa Wn

15.
Filed Nov. 23 1920 J. L. Richard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Still Born (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

.....
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary)
.....(Duration) .....yrs.....mos.....ds.
(Signed) W. A. Nixon M. D.
.....19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Tekoa	Nov 24 1920
20. UNDERTAKER	**ADDRESS**
C. L. Schulerud	Tekoa

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 21
Primary Registration District No.
File No. 1 32131
Registered No. 25

1. **PLACE OF DEATH**
County of Benewah
City of Desmet
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Andrew Bishop
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** M

4. **COLOR OR RACE** Indian

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** Single (Write the word.)

6. **DATE OF BIRTH** Feb 20 1901 (Month) (Day) (Year)

7. **AGE** 19 Yrs. 8 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Idaho

10. **NAME OF FATHER** Louis Bishop

11. **BIRTHPLACE OF FATHER** (State or Country) Idaho

12. **MAIDEN NAME OF MOTHER** Rosalie Thomas

13. **BIRTHPLACE OF MOTHER** (State or Country) Ida

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant)
(Address)

15. Filed Nov. 6 1920 J. E. Buhan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Nov. 3 1920 (Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 19 , to 19 , that I last saw h alive on 19 , and that death occurred on the date stated above, at M. The CAUSE OF DEATH* was as follows:
Consumption -
no doctor attended
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Desmet, Idaho — **DATE OF BURIAL** Nov 6 1920

20. **UNDERTAKER** J. Falcon — **ADDRESS** Desmet, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51083

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32132
Registered No. 57

1. **PLACE OF DEATH**
County of Benewah
City of St Maries
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 32
Primary Registration District No. 2049
(No. ..... , ... St.)

2. **FULL NAME** Wm B Washington

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male
4. **COLOR OR RACE**: White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: June (Month) 17 (Day) 1868 (Year)

7. **AGE**: 52 Yrs. 5 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Canada

10. **NAME OF FATHER**: James Washington

11. **BIRTHPLACE OF FATHER** (State or Country): England

12. **MAIDEN NAME OF MOTHER**: Bridgie Durcher

13. **BIRTHPLACE OF MOTHER** (State or Country): Ireland

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mickey Washington
(Address) Pritchard Idaho

15. Filed Nov 30 1920 — H E Hunt — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Nov (Month) 30 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on 19 9
and that death occurred on the date stated above, at 11:00 A.M.

The CAUSE OF DEATH* was as follows:
Accidentally Struck by Train #18 C.M.&St.P. RR. in yards and Instantly Killed.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Halcion Coroner Benewah Co. I. D.
11/30 1920 (Address) St Maries Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Woodlawn — **DATE OF BURIAL**: Dec 2 1920

20. **UNDERTAKER**: H E Hunt Co. — **ADDRESS**: St Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32133

Registered No. 56

1. PLACE OF DEATH

County of Benewah

City of St. Maries

(No. ....., ... St.)

Registration District No. 32

Primary Registration District No. 2049

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas R Vine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	

6. DATE OF BIRTH: June (Month) 17 (Day) 1843 (Year)

7. AGE: 77 Yrs. 5 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Thomas R Vine Sr.

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: D. V.

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Vine
(Address) Old St. Maries

15. Filed Nov 27 1920 H E Hunt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920 to Nov 24 1920 that I last saw h.. alive on Nov 24 1920 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(Duration) ..... Yrs. 3 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Bonnell M. D.

11/24 1920 (Address) St. Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	11/26 1920

20. UNDERTAKER	ADDRESS
H E Hunt Co	St. Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 32134
Registered No. 55

1. PLACE OF DEATH

County of Bennewah
City of St Maries (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Coy Shepherd

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Mansfield Shepherd

11. BIRTHPLACE OF FATHER (State or Country): No Carolina

12. MAIDEN NAME OF MOTHER: Della Barden

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mansfield Shepherd
(Address) St Maries

15. Filed Nov 23 1920 — H E Hunt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1920 to Nov 23 1920, that I last saw h[im] alive on Nov 20 1920, and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:

Marasmus

..... (Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O O Platt M. D.
Nov 23 1920 (Address) St Maries Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodlawn — DATE OF BURIAL: 11/23 1920

20. UNDERTAKER: H E Hunt Co. — ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 82
Primary Registration District No. 2049
File No. 32135
Registered No. 54

1. PLACE OF DEATH
County of Bonneville
City of Saint
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Gilbert

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	white	single (Write the word.)

6. DATE OF BIRTH
not known
(Month) (Day) (Year)

7. AGE 75 Yrs. ..... Mos. ..... ds. apparently
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work retired farmer
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) not known

10. NAME OF FATHER not known

11. BIRTHPLACE OF FATHER (State or Country) not known

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER (State or Country) not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) ....
(Address) Ivins.

15. Filed Nov 19 1920 H E Grant Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
not known
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1920 to Nov 19 1920
that I last saw him ~~alive on~~ dead Nov 12 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Exposure & Starvation, was subject to Rheumatism & Heart Trouble
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H L Alcorn Coroner. ~~M. D.~~
11/19 1920 (Address) St Maries, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Woodlawn	11/20 1920
20. UNDERTAKER Mitchell & Manager	ADDRESS St Maries.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2049
(No. ..... St.)

File No. 32136
Registered No. 5-3

1. PLACE OF DEATH

County of Bonneville
City of St Maries

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary E. Scarbery

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Dec. (Month) ..... (Day) 1868 (Year)

7. AGE: 52 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Stapleton Houghton

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Hannah Martin

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Oscar F. Scarbery
(Address) Morley Idaho

15. Filed Nov 11 1920 H E Blount Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1920 to Nov 11 1920
that I last saw h[illegible] alive on Nov 11 1920
and that death occurred on the date stated above, at 1 A. M.
The CAUSE OF DEATH* was as follows:

Intestinal toxemia [illegible]

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Myocarditis
(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) Blomvall M. D.
11/11 1920 (Address) St Maries

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Worley Idaho
DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: H E Blount Co.
ADDRESS: St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Benewah

City of Santa

Registration District No. 32

Primary Registration District No. 2049

(No. .... St.)

File No. 32137

Registered No. 52

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Michael Garey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 10 (Day) 1865 (Year)

7. AGE: 55 Yrs. ..... Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Hotel keeper

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wis.

10. NAME OF FATHER: Nat Emma

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. M. Garey

(Address) Santa Ida

15. Filed Nov 7 1920 H E Hunt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1920, to Nov 6 1920, that I last saw h.. alive on Nov 4 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
Arteriosclerosis

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) Carcinoma of bladder

(Duration ..... yrs. 6 mos. ..... ds.

(Signed) C D Mac ..... M. D.

Nov 6 1920 (Address) St Maries Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Idaho

DATE OF BURIAL 1920

20. UNDERTAKER: H E Hunt

ADDRESS: St. Maries

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
(No. ..... , ... St.)

File No. 32138
Registered No. 51

1. PLACE OF DEATH
County of Benewah
City of St. Maries
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Kellner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single. (Write the word.)

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
about 40 years
Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Woodsman
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER Charles Kellner

11. BIRTHPLACE OF FATHER
(State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. W. Stewart
(Address) .....

15. Filed Nov. 3 1920 H E Hunt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7.30 P.M.

The CAUSE OF DEATH* was as follows:
Boy jumped Schule and Striking Cement Post about Chest causing Internal Injuries resulting in death in about 4 hours.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H L Alcorn Coroner M.D.
Benewah Co. Ida.
Nov. 4 1920 (Address) St Maries Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
St Joe Indiana	Nov 5 20
20. UNDERTAKER	**ADDRESS**
H E Hunt Co.	St Maries

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2049
File No. 32139
Registered No. 50

1. PLACE OF DEATH
County of Benewah
City of St Maries (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Albert H Ferrell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: June (Month) 9 (Day) 1860 (Year)

7. AGE: 59 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: woodsman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Chas H. Ferrell

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Nancy June Clow

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George A. Ferrell
(Address) Spokane Wash

15. Filed Nov 2 1920 H E Smith Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1920 to Nov 2 1920 that I last saw h[illegible] alive on Nov 2 1920 and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:
Internal injuries resulting from a fall
(Duration) ..... Yrs. ..... mos. 6 hrs

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O B Smith M. D.
Nov 2 1920 (Address) St Maries Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 6 hrs. 5 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? at Flat Cr. Camp
Former or usual residence Spokane Wash

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash — DATE OF BURIAL: 11/5 1920

20. UNDERTAKER: H E Smith Co — ADDRESS: St Maries

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ....., ... St.)
Registration District No. 116
Primary Registration District No. 2195
File No. 32340
Registered No. 42
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.
2. FULL NAME James Earl Courtney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. March 15 1918 (Month) (Day) (Year)
7. AGE: 2 Yrs. 8 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): —
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: Elmer Courtney
11. BIRTHPLACE OF FATHER (State or Country): Kansas
12. MAIDEN NAME OF MOTHER: Emma Cloud
13. BIRTHPLACE OF MOTHER (State or Country): Nebraska
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Grace Courtney
(Address) Aberdeen Ida
15. Filed Nov 26 1920 M. C. McCutchen Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 26 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1920, to Nov 26 1920, that I last saw him alive on Nov 25 1920, and that death occured on the date stated above, at 24 M.
The CAUSE OF DEATH* was as follows:
Influenza
(Duration) 9 ds.
Contributory (Secondary) Empyaemia
(Duration 6 ds.
(Signed) M. C. McCutchen M. D.
11/26 1920 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Ida — DATE OF BURIAL: 11/28 1920
20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

32141

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 2195
File No. 3
Registered No. 41

1. PLACE OF DEATH.
County of Buchan
City of Stirling (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed Aldous

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. Nov (Month) 25 (Day) 1920 (Year)
7. AGE: — Yrs. — Mos. — ds. IF LESS than 1 day how many — hrs. or 5 min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work...
(b) General nature of industry, business, or establishment in which employed (or employer)...
9. BIRTHPLACE (State or Country): Idaho
10. NAME OF FATHER: John Henry Aldous
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Emily Charlotte Berlin
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. H. Aldous
(Address) Stirling Ida
15. Filed Nov 25 1920 M. Cameron
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 25 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1920, to Nov 25 1920, that I last saw h— alive on Nov 25 1920 and that death occured on the date stated above, at 9 a.m.
The CAUSE OF DEATH* was as follows:
Atelectasis
5 minutes (Duration) — Yrs. — mos. — ds.
Contributory (Secondary)
(Duration — yrs. — mos. — ds.
(Signed) M. C. Mackinnon M. D.
25 1920 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State ....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Ida — DATE OF BURIAL: Nov 27 1920
20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116 32142
Primary Registration District No. 2155
File No. 3
Registered No. 40

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lee Snow

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Single

6. DATE OF BIRTH. Apr 30 (Month) (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work. —
(b) General nature of industry, business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER William L Snow

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER May Morrison

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Herman Snow
(Address) Aberdeen Ida

15. Filed 11/13 20 mcmentinnen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
nov (Month) 12 (Day) 20 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from birth 191..., to nov 12 191 20, that I last saw h— alive on nov 5 191 20, and that death occured on the date stated above, at 11A M.

The CAUSE OF DEATH* was as follows:
premature birth.
(7½ month)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) mcmentinnen M. D.
11/13 19 20 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL I. O. O. F. Aberdeen — DATE OF BURIAL 11/13 191 20

20. UNDERTAKER Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 121

Primary Registration District No. 1007

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 5213

Registered No. 108

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

(No. 360 West Judicial St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Byers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Nov (Month) 6 (Day) 1834 (Year)

7. AGE: 85 Yrs. 10 Mos. 25 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: Abraham Hattra

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Hart

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laura Gaynor

(Address) Blackfoot, Idaho.

15. Filed ..... 19..... Mrs. Nelle E. Eaton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1920 to Oct 1 1920

that I last saw her alive on Oct 1 1920

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion - due to Myocarditis,

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Nephritis

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H J Simmons M. D.

10/2 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Harris Town Penn | DATE OF BURIAL ..... 19.....

20. UNDERTAKER ..... ADDRESS Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32144

Registered No. 109

1. PLACE OF DEATH

County of Bingham

City of Blackfoot Ida (No. Rose St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12

Primary Registration District No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thelma Edith Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 8 (Day) 1920 (Year)

7. AGE: Yrs. 4 Mos. 24 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William H Jackson

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Hazel Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William H. Jackson

(Address)

15.

Filed ..... 19 .....

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2d (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2d 1920 to Oct 2d 1920 that I last saw h.er alive on Oct 2d 1920 and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Acute enteritis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H J Summeres M. D.

10/2 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fern city cem | DATE OF BURIAL: 10-3 1920

20. UNDERTAKER: E Funk | ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32145
Registered No. 116

1. PLACE OF DEATH
County of Bingham
City of Wapello
(No. ....., ... St.)
Registration District No. 121
Primary Registration District No. 2192
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marcia Gonzales
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Mex
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov. (Month) 15 (Day) 1919 (Year)

7. AGE: 10 Yrs. 17 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Bingham Co Ida

10. NAME OF FATHER: Ramos Gonzales

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: Francesca Herrera

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ramon Gonsales
(Address) .....

15. Filed Oct. 3 1920 Mrs Nellie E. Foster
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ investigated death 19..., to ..... 19.....
~~that I last saw h..... alive on ..... 19.....~~
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:
Convulsions
.....
.....
.....(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. E. Lakie M. D.
Oct 3 1920 (Address) County Physician Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferry City Cemetery
DATE OF BURIAL: Oct 3 1920

20. UNDERTAKER: Ramon Gonzales
ADDRESS: Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121

Primary Registration District No. 2194

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32146

Registered No. 111

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Bingham

City of Firth

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 3 (Day) 1867 (Year)

7. AGE: 53 Yrs. 0 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Peter Edson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Olga Anderson

(Address) Firth Idaho

15. Filed Oct 12 1920 Mrs. Nalen E. Pat

Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1 1920, to Oct 12 1920, that I last saw h— alive on Aug 1 1920, and that death occured on the date stated above, at 6-48 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) H. C. Mitchell M. D.

10/12 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aberdeen Idaho — DATE OF BURIAL: Oct 14 1920

20. UNDERTAKER: E T Peck — ADDRESS: Blackfoot Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 32147
Registered No. 112

1. PLACE OF DEATH

County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.
(No. Dr H J Simmons Hospital St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Jeannie R Keen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: ..... 1 ..... (Month) (Day) (Year)

7. AGE: 58 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: .....

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C F Hendrix
(Address) Pocatello Oregon

15. Filed Oct 16 1920 Mina [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 14 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1920 to Oct 14 1920
that I last saw h.. alive on Oct 14 1920
and that death occurred on the date stated above, at 11 P M.
The CAUSE OF DEATH* was as follows:
Diabetis mellitis
.....
.....
.....(Duration) .....Yrs.....mos.....ds.
Contributory (Secondary) .....
.....(Duration) .....yrs.....mos.....ds.
(Signed) H J Simmons M. D.
Oct 16 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Albany N.Y. | DATE OF BURIAL .....19.....

20. UNDERTAKER: E J Funk | ADDRESS Blackfoot Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 32148
Registered No. 1758

1. PLACE OF DEATH

County of Bingham
City of Blackfoot (No. ..... Street, Shelling Ave)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harriett Mabern

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	Widow

6. DATE OF BIRTH Aug 17 1854 (Month) (Day) (Year)

7. AGE 66 Yrs. 1 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER — Mabern

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde Keasey.
(Address) Rupert Idaho.

15. Filed Oct 19 1920 M. N. E. Falconer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 14 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~Dec 19~~ to ~~19~~

that I last saw her alive on Oct 9 1920, and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. J. Funk Coroner

1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bingham County	Oct 19 1920

20. UNDERTAKER	ADDRESS
E. J. Funk	Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 32149
Registered No. 114

1. PLACE OF DEATH
County of Bingham
City of Rose Prct.
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Waiora Goff.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: May (Month) 5 (Day) 1919 (Year)

7. AGE: 1 Yrs. 5 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rose Idaho

10. NAME OF FATHER: Joseph H. W. Goff

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary R Love

13. BIRTHPLACE OF MOTHER (State or Country): South Africa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joseph H W Goff
(Address) Rose

15. Filed Oct 19 1920 Mrs H E [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1920, to Oct 17 1920
that I last saw h— alive on Oct 17 1920
and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) —
(Duration) — yrs. — mos. — ds.

(Signed) F. W Mulcahy M. D.
10/18 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shelley Idaho	Oct. 19
20. UNDERTAKER: Ed L Egli	ADDRESS: Blackfoot Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 32152
Registered No. 117

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot
(No. At Sugar Factory Grounds St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Rosa Flores Martinez

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Dec (Month) 10 (Day) 1888 (Year)

7. AGE: 32 Yrs. 10 Mos. — ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Vintage Flores

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Adolfo Martinez
(Address):

15. Filed Oct 29 1920 Mrs N. E. Paine Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 27 1920, to Oct. 28 1920, that I last saw her alive on Oct. 28 1920, and that death occured on the date stated above, at 8. A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration — yrs. — mos. — ds.

(Signed) F. C. Wheeler M. D.
Oct 29 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ferry City Cemetery — DATE OF BURIAL: 191

20. UNDERTAKER: E. J. Funk — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24058

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 57

Primary Registration District No. 2025

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32153

Registered No. 41

1. PLACE OF DEATH.

County of Blaine

City of Carey

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Cody.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. July (Month) 18 (Day) 1919. (Year)

7. AGE: 1 Yrs. 2 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho Falls, Ida.

10. NAME OF FATHER: J. M. Cody.

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin.

12. MAIDEN NAME OF MOTHER: Vinnie Coleman.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. M. Cody

(Address) Salt Lake, Utah.

15. Filed Nov. 7 1920 R. H. Wright Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 2 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1920 to Sept 2 1920; that I last saw h[illegible] alive on Sept 2 1920 and that death occured on the date stated above, at 11:50 P.M.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) —

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Florence O Snyder M. D.

10-3 1920 (Address) [illegible]

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake, Utah. DATE OF BURIAL 191

20. UNDERTAKER: P. S. Harris. ADDRESS Hailey.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2022.
(No. ..... St.)

File No. 32154
Registered No. 40

1. **PLACE OF DEATH**
County of Blaine
City of Gannett
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Ruby Arvilla Cooper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Female
4. **COLOR OR RACE** Wht
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.)

6. **DATE OF BIRTH** ..... 1 ..... (Month) (Day) (Year)

7. **AGE** 2 Yrs. 1 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Gannett - Ida

10. **NAME OF FATHER** Isaac L. Cooper

11. **BIRTHPLACE OF FATHER** (State or Country) Utah

12. **MAIDEN NAME OF MOTHER** Mary Edmiston

13. **BIRTHPLACE OF MOTHER** (State or Country) Utah

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Isaac L. Cooper
(Address) Gannett, Ida

15. Filed 10 - 19 1920 R. H. Wright
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Oct 7 1920
(Month) (Day) (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Sept. 30 1920 to Oct. 6 1920
that I last saw h.e.r alive on Oct. 6 1920
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Cholera Infantum.

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Robert H. Wright M. D.
10-8 1920 (Address) Hailey, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Picabo, Ida — **DATE OF BURIAL** 10-9 1920

20. **UNDERTAKER** R. D. Harris — **ADDRESS** Hailey

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 57

Primary Registration District No. 2022

File No. 32155

County of Blaine

City of Ketchum (No. ....., ... St.)

Registered No. 42

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Grandgean Leflang.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May 4. 1920.
(Month) (Day) (Year)

7. AGE: ..... yrs. 6 mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Boise, Idaho.

10. NAME OF FATHER: W. G. Leflang.

11. BIRTHPLACE OF FATHER (State or Country): Nebraska.

12. MAIDEN NAME OF MOTHER: Gertrude Elliott.

13. BIRTHPLACE OF MOTHER (State or Country): Washington D.C.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. G. Leflang
(Address) Ketchum, Idaho.

15. Filed Nov - 5 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dutton.
Oct. 18. 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1920, to Oct 17 1920, that I last saw h[illegible] alive on Oct 17 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Pulmo Tuberculosis

(Duration) ..... yrs. ..... mos. 24 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. H. Dalton M. D.
19..... (Address) Hailey Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ketchum, — DATE OF BURIAL: Oct-20 1920

20. UNDERTAKER: P. D. Harris — ADDRESS: Hailey -

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Gannett
(No. ....., ... St.)

Registration District No. 57
Primary Registration District No. 2022

File No. 3215
Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Burnice Poulson.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female.	White	Single

6. DATE OF BIRTH
Oct. (Month) 17. (Day) 1920. (Year)

7. AGE
..... yrs. ..... mos. 3. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ~
(b) General nature of industry business, or dstablishment in which employed (or employer) ~

9. BIRTHPLACE (State or Country) Gannett Idaho.

10. NAME OF FATHER W. F. Poulson.

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Francis White

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) x W. F. Poulson
(Address) Gannett, Idaho,

15.
Filed 11-5 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Oct. (Month) 20- (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191..., that I last saw her alive on Oct-17 1920 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:
Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert A. Wright M. D.
10-22 1920 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gannett, | DATE OF BURIAL: 10-21 1920

20. UNDERTAKER: J. D. Harris | ADDRESS: Hailey

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine,
City of Gannett,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2022
(No. ....., ... St.)

File No. 3357
Registered No. 45

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joe C. Vasco.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	single

6. DATE OF BIRTH
Aug. (Month) 19 (Day) 1920 (Year)

7. AGE
..... yrs. 2 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ✓
(b) General nature of industry business, or dstablishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Jos R. Vasco

11. BIRTHPLACE OF FATHER (State or Country) Portugal.

12. MAIDEN NAME OF MOTHER Eva Sherbine.

13. BIRTHPLACE OF MOTHER (State or Country) Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) x Joe R Vasco
(Address) Gannett, Ida.

15.
Filed 11-5 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

W Right.

16. DATE OF DEATH Oct. (Month) 28 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-27- 1920 to Oct-28 1920
that I last saw h~~im~~ alive on Oct-27 1920
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.
10-29 1920 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Bellevue, Ida. DATE OF BURIAL: Oct 29 1920.

20. UNDERTAKER: R. D. Harris ADDRESS: Hailey, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2022
File No. 32158
Registered No. 44

1. PLACE OF DEATH.
County of Blaine,
City of Hailey,
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anna L. Ellingsen.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH: March 23, 1871. (Month) (Day) (Year)

7. AGE: 49 yrs. 7 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden.

10. NAME OF FATHER: Mr. Larsen.

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X J. J. Ellingsen
(Address) Hailey, Ida.

15. Filed Oct-26 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

Wright.

16. DATE OF DEATH: Oct. 25- 1920. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-18 1920 to Oct 25 1920 that I last saw h e alive on Oct-24 1920 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Mitral Heart Lesion

(Duration) 3 yrs. mos. ds.
Contributory (Secondary) Pleurisy
(Duration) yrs. mos. ds.

(Signed) Robert H. Wright M. D.
10-26 1920 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hailey | DATE OF BURIAL: 10-29 1920

20. UNDERTAKER: [illegible] | ADDRESS: Hailey

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

Revised

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

Primary Registration District No. 215-5

File No. 22159

County of Bonner

City of Hope, Ida.

(No. Hope, Ida. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Rea Ferguson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: April, 6, 1886 (Month) (Day) (Year)

7. AGE: 34 Yrs. 6 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House Wife.

(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Francis Twiss.

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Marie E. Robinson.

13. BIRTHPLACE OF MOTHER (State or Country): Maine.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J.B.Gardner.

(Address) Sandpoint, Ida.

15. Filed Oct 12 1920 FLOYD [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct, 10, 20. (Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct- 3 19 20, to Oct-10 19 20 that I last saw h..er.... alive on Oct-10 19 20 and that death occurred on the date stated above, at 10P M.

The CAUSE OF DEATH* was as follows:

Pneumonia,

..... (Duration) ..... Yrs. ..... mos. 11 ds.

Contributory (Secondary) Toxemia

..... (Duration) ..... yrs. ..... mos. 11 ds.

(Signed) Floyd Edwards M. D.

Oct, 19 20. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida.

DATE OF BURIAL: Oct, 12, 19 20.

20. UNDERTAKER: B.W.Pugh,

ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

Primary Registration District No. 2133

File No. 32160

Registered No.

County Bonner

City of Sandpoint, Ida. (No. 520 Cedar St St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm James Davis.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married. (Write the word.)

6. DATE OF BIRTH: July, 24, 1872 (Month) (Day) (Year)

7. AGE: 47 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laundryman

(b) General nature of industry, business or establishment in which employed (or employer): Employer.

9. BIRTHPLACE (State or Country): New Brunswick.

10. NAME OF FATHER: James Davis.

11. BIRTHPLACE OF FATHER (State or Country): Canada.

12. MAIDEN NAME OF MOTHER: Barbria Reed,

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Davis.

(Address) Sandpoint, Ida.

15. Filed Nov 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct, (Month) 4 (Day) -20. 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 29 1920 to Oct 4 1920 that I last saw him alive on Oct 4 1920, and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

acute intestinal obstruction

(Duration) Yrs. mos. 3 ds.

Contributory (Secondary) Chronic gastro enteritis

(Duration) 2 yrs. mos. ds.

(Signed) M. R. Wallentine M. D.

Oct., 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Oct. 6. 1920.

20. UNDERTAKER: B. W. Pugh. ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 78

Primary Registration District No. 2115

File No. 3216

County of Bonner

City of Sandpoint (No. 28 Mill Town. St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julius Solberg.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married.

6. DATE OF BIRTH

Unknown (Month) (Day) 1870 (Year)

7. AGE

50 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Merchant.

(b) General nature of industry, business or establishment in which employed (or employer) Employer.

9. BIRTHPLACE (State or Country) Norway.

10. NAME OF FATHER Olie Solberg.

11. BIRTHPLACE OF FATHER (State or Country) Norway.

12. MAIDEN NAME OF MOTHER Marti Solberg.

13. BIRTHPLACE OF MOTHER (State or Country) Norway.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Tom Solberg.

(Address) Sandpoint, Ida.

15. Filed Oct 21 1920 FLOYD G. WENDLE Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. (Month) 17. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1919, to Oct 17 1920. that I last saw him alive on Oct 16. 1920. and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis.

(Duration) Not known. yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. F. Pugh M. D.

Oct, 20 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Sandpoint, Ida. DATE OF BURIAL Oct. 19, 1920.

20. UNDERTAKER B. W. Pugh. ADDRESS Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32162

Registered No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH

County of Bonner

City of Laclede (No. Laclede, Ida. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Gardner Rick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or widowed)

6. DATE OF BIRTH: May (Month) 22 (Day) 1859 (Year)

7. AGE: 61 Yrs. 5 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Woodland, Cal.

10. NAME OF FATHER: Wm. D. Emery

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Lucy S. Spaulding

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Dr. F. W. Didier,

(Address) Laclede, Ida.

15. Filed Nov 8 1920 F. W. Didier
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 5. (Day) -20. (Year) 19

17. I HEREBY CERTIFY, That I attended deceased from Aug 5. 1920, to Nov 5 1920 that I last saw h...er... alive on Nov 5 1920 and that death occurred on the date stated above, at 6 00 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma Venturculi

(Duration) Two Yrs. — mos. — ds.

Contributory (Secondary) Asthenia

— (Duration) — yrs. — mos. 15 ds.

(Signed) F. W. Didier M. D.

Nov. 8 1920. (Address) Laclede, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dallas, Ore. DATE OF BURIAL 19

20. UNDERTAKER: B. W. Pugh ADDRESS: Sandpoint, Ida.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 81
Primary Registration District No. 2058
File No. 732163
Registered No. 28

1. PLACE OF DEATH.
County of Bonner
City of Kaelede Ida. (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (Not named) Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. Nov (Month) 25" (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 1/6 ds.
IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... (Baby)
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) near Morton Ida Bonner Co

10. NAME OF FATHER Wm H. Jones.

11. BIRTHPLACE OF FATHER (State or Country) missouri

12. MAIDEN NAME OF MOTHER Elsie B. Blish

13. BIRTHPLACE OF MOTHER (State or Country) wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. H. Jones
(Address) Morton Ida.

15. Filed Nov 26 1920 J. W. Dibler Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1920, to Nov 26 1920, that I last saw him alive on Nov 26 1920, and that death occured on the date stated above, at 4:00 A M.

The CAUSE OF DEATH* was as follows:

asthenia

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration — yrs. — mos. — ds.

(Signed) J. W. Dibler M. D.
Nov 26 1920 (Address) Kaelede Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kaelede. Ida. DATE OF BURIAL: Nov. 26 1920

20. ~~UNDERTAKER~~ W. H. Jones ADDRESS: Morton Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonner

City of Colburn.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 2103

(No. On Ranch. (Near Colburn.) St.)

File No. 32164

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvin Oliver.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single.

6. DATE OF BIRTH

March, 30, -20. 1917
(Month) (Day) (Year)

7. AGE

3 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work School Boy.

(b) General nature of industry, business or establishment in which employed (or employer) At Home.

9. BIRTHPLACE (State or Country) Ida.

10. NAME OF FATHER Chas Oliver.

11. BIRTHPLACE OF FATHER (State or Country) Penna.

12. MAIDEN NAME OF MOTHER Mary Rosmier.

13. BIRTHPLACE OF MOTHER (State or Country) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Oliver.

(Address) Colburn. Ida.

15. Filed Nov 8 1920 FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct. 20. -20. 19
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-1 1920 to Oct-20 1920 that I last saw him alive on Oct-16 1920 and that death occurred on the date stated above, at 4 A. M.

The CAUSE OF DEATH* was as follows:

Enteritis

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Floyd E. Wendle M. D.

Oct, 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Colburn, Ida. DATE OF BURIAL Oct., 22, 1920.

20. UNDERTAKER B.W.Pugh. ADDRESS Sandpoint, Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32165
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Kooteani
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 2157
(No. Kooteani, Ida. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME (Infant) Little.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 26 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Bert M. Little.

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Sallie Stull

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr. Wendel,
(Address) Sandpoint, Ida.

15. Filed Nov 8 1920 FLOYD G. WENDEL Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct-26 1920, to Oct-28 1920 that I last saw him alive on Oct-27 1920, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Not Valvular Heart Leakage

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Floyd G. Wendel M. D.
Oct. 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Oct. 29 - 1920

20. UNDERTAKER: B.W.Pugh. ADDRESS: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 23
Primary Registration District No. 2552
File No. 32166
Registered No. 162

1. PLACE OF DEATH

County of Bannock
City of Idaho Falls
(No. 139-13th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Levi Harvey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Apr. (Month) 13 (Day) 1841 (Year)

7. AGE: 79 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Vermont

10. NAME OF FATHER: Levi Harvey

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Don't know

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ira Lantis
(Address) Idaho Falls

15. Filed Nov 8 1920 W Kinnaird Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 21 1920 to Oct 28 1920 that I last saw h.. alive on Oct. 27 1920 and that death occurred on the date stated above, at 2. P.M.

The CAUSE OF DEATH* was as follows: Chronic Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Dropsy

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. P. Sidwell M. D.

11/8 1920 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cem. | DATE OF BURIAL: Oct 30 1920

20. UNDERTAKER: Stiff & Haynes | ADDRESS: Idaho Falls Ida.

Mr Soderquist

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32167

Registered No. 161

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 2170

(No. 1 Leonard St. Hospital)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dora Bashore

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept 23 1874
(Month) (Day) (Year)

7. AGE: 45 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: John Arnbolt

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wallace Bashore
(Address) Hamer Ida

15. Filed Nov 6 1920 W. Hammond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 23 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1920 to Sept 23 1920 that I last saw h... alive on ... 19..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Uremic Poisoning

(Duration) 2 Yrs. ... mos. 21 ds.

Contributory (Secondary) Flu Toxic

(Duration) ... yrs. ... mos. ... ds.

(Signed) C. W. Clemens M. D.

19... (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill | DATE OF BURIAL: Sept 23 1920

20. UNDERTAKER: Cliff Hayes | ADDRESS: Idaho Falls

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Dr Clemens

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32168

Registered No. 140

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 21 V-0

(No. General Hosp. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Hattie Nichols.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 1 (Day) 1883 (Year)

7. AGE: 37 Yrs. 8 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mass

10. NAME OF FATHER: Erastus Emmons Groves

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Ellen T Smith

13. BIRTHPLACE OF MOTHER (State or Country): Mass.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Luther C Nichols

(Address) Dubois Ida

15. Filed Nov 1 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1920 to Oct 14 1920 that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A W Allen M. D.

19..... (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: Oct 15 1920.

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 73 100

Primary Registration District No. 21-6

(No. Spruce Hosp. St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32169

Registered No. 1-9

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin L Hammon

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Jan (Month) 4 (Day) 1900 (Year)

7. AGE: 19 Yrs. 7 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Samuel Hammon

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Nancy Collins

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nancy Hammon

(Address) Idaho Falls Ida

15. Filed Nov 6 1920 W Hammond Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: aug (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 12 1920 to Aug 26 1920 that I last saw him alive on Aug 20 1920 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Later Pneumonia

(Duration) Yrs. 2 weeks ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) W Hammond M. D.

1920 (Address) Last Forever Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mito Ida. DATE OF BURIAL: Aug 27 1920

20. UNDERTAKER: Cliff Hayes ADDRESS: Idaho Falls

W Hammond

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2 1 4 0
File No. 32170
Registered No. 1 1 8

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. 324 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Scarborough

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (Write the word.)

6. DATE OF BIRTH: May (Month) 15 (Day) 1820 (Year)

7. AGE: Yrs. 4 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Charles Ida.

10. NAME OF FATHER: H H Scarborough.

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Audra Howley.

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H H Scarborough
(Address) Idaho Falls Ida.

15. Filed Nov 8 1920 — W Kennard, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1920, to Sept 4 1920, that I last saw h alive on — 19—, and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Measles

(Duration) Yrs. mos. ds.
Contributory (Secondary) Pneumonia last
(Duration) yrs. mos. ds.
(Signed) W Kennard M. D.
19 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Sept 6 1920

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

Dr. Kennard

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32171

Registered No. 14-7

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

(No. 10 [illegible] St.)

Registration District No. 3

Primary Registration District No. 21-0

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Horace Pendleton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 6 (Day) 1909 (Year)

7. AGE: 11 Yrs. 6 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls, Idaho

10. NAME OF FATHER: G. W. Pendleton

11. BIRTHPLACE OF FATHER (State or Country): Colorado

12. MAIDEN NAME OF MOTHER: Olive E. Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) [illegible]

(Address) [illegible]

15. Filed Sep 8 1920

[illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw him alive on Aug 16 1920

and that death occurred on the date stated above, at 12 [illegible] M.

The CAUSE OF DEATH* was as follows: Accidental Gunshot Wound in back through liver & Abdominal Cavity (Duration) Instant

Contributory (Secondary) To consider in regard to entertaining target shooting (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. W. Pendleton M. D.

9-17 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Aug 20 1920

20. UNDERTAKER: Jeffs Hayes — ADDRESS: Idaho Falls

Dr. Pendleton.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

STAR-TIMES CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32172

Registered No. 1 V 6

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 21 V 0

(No. Bingham ave. St.)

2. FULL NAME John Henige

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH: May (Month) 19 (Day) 1859 (Year)

7. AGE: 61 Yrs. V Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Henry

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Barbra Stuart

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Susanna Henige
(Address) Idaho Falls Ida.

15. Filed Nov 6 1920 C.E. Summard Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 4. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1920, to Nov 4 1920, that I last saw h.. alive on nov 4 1920, and that death occurred on the date stated above, at 3:20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis and Valvular endocarditis

(Duration) ? Yrs. mos. ds.

Contributory (Secondary) Rheumatism fever many yrs ago.

(Duration) yrs. mos. ds.

(Signed) H R Hatch M. D.

Nov 5 1920 (Address) Idaho Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Oct 6 1920

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

H. R. Hatch

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 5 6
File No. 21123
Registered No. 1 1 5 -

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls.
(No. 10 — E. St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Delphine Chapin.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Feb (Month) 27 (Day) 1841 (Year)

7. AGE: 79 Yrs. 5 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Jacob Hewson

11. BIRTHPLACE OF FATHER (State or Country): X ?

12. MAIDEN NAME OF MOTHER: Fisher

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clarence Chapin
(Address) E-10 St Idaho Falls

15. Filed Mr 8 1920 W Fennand
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 16 1920, to Aug 18 1920, that I last saw h[er] alive on Aug 18 1920, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Senility.
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J E Rogers M. D.
1920 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Lane — DATE OF BURIAL: Aug 13 1920

20. UNDERTAKER: Leffler Hayes — ADDRESS: Idaho Falls, Ida.

Rodgers

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 3614
Registered No. 157

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Fanning
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 22. (Day) 1845 (Year)

7. AGE: 75 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Merchants
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Patrick Fanning

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Bridget Murphy

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. W. Fanning
(Address) Idaho Falls, Ida.

15. Filed Nov 12 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 7 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1920, to Nov 7 1920, that I last saw him alive on Nov 7 1920, and that death occurred on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) Yrs. 9 mos. ..... ds.
Contributory (Secondary) Arteriosclerosis
(Duration) 5 yrs. ..... mos. ..... ds.

(Signed) C. E. Allen M. D.
11/11/20 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Idaho Falls Idaho

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: Nov 10 1920

20. UNDERTAKER: Taylor Eleson Mortuary — ADDRESS: Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 12175
Registered No. 113

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. 32 Broadway St.)
Registration District No. 3
Primary Registration District No. 21-2
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Lindsay.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Nov. (Month) 26. (Day) 1866 (Year)

7. AGE: 53 Yrs. 9 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: Wm Lindsay

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Betsy Scott

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm Lindsay Jr
(Address) Idaho Falls.

15. Filed Sept 18 1920 [signature] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 12, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1920, to Sept 12 1920, that I last saw h.. alive on Sept 12 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Stomach poisoning - Gastro-Enteritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Harry C. Williams M. D.

Sept 18 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Sept 15 1920

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls

Dr. Wilson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21N-0
File No. 32176
Registered No. 1N-2

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. 1 mile S Idaho Falls St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Gieschan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Feb. 19 (Month) (Day) 1918 (Year)

7. AGE: 2 Yrs. 6 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: No.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Henry Gieschan

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Edna Plumer

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Henry Gieschan
(Address) Idaho Falls Ida.

15. Filed Sept 18 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 17 (Month) (Day)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 17 1920, to Sept 17 1920, that I last saw h... alive on Sept 17 1920, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

Automobile accident. Neck broken and Chest crushed. Lived about 15 minutes.

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) Harry L. Wilson M. D.

9/20 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Sept 21 1920

20. UNDERTAKER: Cliff Hayes — ADDRESS: Idaho Falls Ida

Dr. Wilson

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 3217

Registered No. 171

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2170

(No. 50 Lincoln Hwy. St.)

2. FULL NAME Wm Hoch

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 27 (Day) 1861 (Year)

7. AGE: 59 Yrs. 1 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Rancher

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Samuel Hoch.

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Mary Hocker.

13. BIRTHPLACE OF MOTHER (State or Country): Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W E Thomas

(Address) Lincoln Ida.

15. Filed Oct 8 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9-16- 1920, to 9-22- 1920 that I last saw h- alive on 9-22- 1920 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Endocarditis following Pneumonia.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J. C. Hollister M. D.

19 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls

DATE OF BURIAL: Sept 22 1920

20. UNDERTAKER: Jeff C Hayes

ADDRESS: Idaho Falls Ida

Hollister for Haines

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21N-0
File No. 32178
Registered No. 1N-0

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. Capital Ave. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph M. Freeman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH July 5th 1830
(Month) (Day) (Year)

7. AGE 90 Yrs. 2 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Edw Wynn
(Address) Idaho Falls Ida.

15. Filed Sept 20 1920 W. Summers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 6. 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7 1920, to Sept 6 1920
that I last saw him alive on Sept 6 1920
and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) H. D. Spencer M. D.
Sept 20 1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rose Hill | DATE OF BURIAL Sept 1920

20. UNDERTAKER C. F. C. Hayes | ADDRESS Idaho Falls

Dr Spencer.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 22179
Registered No. 149

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls
(No. Spencer Hosp St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Paul R. Gotberg

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Sept (Month) 11 (Day) 1920 (Year)

7. AGE: Child born — Yrs. — Mos. — ds.
IF LESS than 1 day how many — hrs. or 15 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Paul Gotberg

11. BIRTHPLACE OF FATHER (State or Country): Minn

12. MAIDEN NAME OF MOTHER: Fern L Beachy

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Paul L Beachy
(Address) Idaho Falls Ida

15. Filed Oct 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 19..., to ✓ 19..., that I last saw h. ✓ alive on 19..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:

Stillbirth. Dno
Protracted Labor

(Duration) ...Yrs...mos...ds.

Contributory (Secondary)

(Duration) ...yrs...mos...ds.

(Signed) H. R. Spencer M. D.

Oct 7 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death...yrs...mos...days. In the State...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill | DATE OF BURIAL: Sept 11 1920

20. UNDERTAKER: Cliff Hayes | ADDRESS: Idaho Falls

Dr. Spencer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32180

Registered No. 174

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2170

No. Home, 11th St. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME A A Chubb.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov. (Month) 14 (Day) 1882 (Year)

7. AGE: 37 Yrs. 11 Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Telegraph Lineman

(b) General nature of industry, business or establishment in which employed (or employer): O.S.L.R. Co.

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: Jeremiah Chubb

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Kate Atkins

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs A A Chubb.

(Address) Idaho Falls Ida

15. Filed Oct 19 20

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1920 to Oct 14 1920 that I last saw h[illegible] alive on 14 Oct 1920 and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Abscess Larynx & Membranous Pharangitis

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary) Typhoid Fever.

(Duration) yrs. mos. 53 ds.

(Signed) H. D. [illegible] M. D.

19 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill

DATE OF BURIAL: Oct 16 1920

20. UNDERTAKER: Cliff Hayes

ADDRESS: Idaho Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
(No. ..... St.)

Registration District No. 73
Primary Registration District No. 21-0

File No. 32181
Registered No. 147

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Afton B. Helm

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Infant

6. DATE OF BIRTH. July (Month) 25 (Day) 1920 (Year)

7. AGE 0 Yrs. 7 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER N. Helm

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Della Andrus

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) N. Helm
(Address) Idaho City

15. Filed Nov 6 1920 [signature] Local Registrar
Dr Dunkin

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sep (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 25 1920, to Sept 26 1920, that I last saw h[illegible] alive on 26 Sept 1920 and that death occured on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Meso-Cholitis

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Cause

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
9/26 1920 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Idaho Falls | DATE OF BURIAL 9-28 1920

20. UNDERTAKER C. E. Linwoodey | ADDRESS Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32182

Registered No. 146

1. PLACE OF DEATH

County of Bonneville

City of Ida Falls

(No. ..... St.)

Registration District No. 23

Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Carter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Infant

6. DATE OF BIRTH

Oct (Month) 30 (Day) 1920 (Year)

7. AGE

0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER ? Carter

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER Maria Carter

13. BIRTHPLACE OF MOTHER (State or Country) Cannon Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C E Dunwoody

(Address) R D # City

15. Filed Nov 4 1920 W Finnell Local Registrar

Dr Junken

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Oct (Month) 30 (Day) 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1920, to Oct 30 1920, that I last saw h. alive on 30 Oct 1920 and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Due to Delivery
Face Presentation

(Duration) ..... Yrs. ..... mos. 15 Min.

Contributory (Secondary) Coma

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W D Junken M. D.

10/30 1920 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL, OR REMOVAL	DATE OF BURIAL
Idaho Falls	10/30 1920

20. UNDERTAKER C E Dunwoody — ADDRESS Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32186

Registered No. 172

1. PLACE OF DEATH.

County of Bannock Registration District No. 73

City of Ida Falls (No. ....., ... St.) Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virgil R Brunt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Aug (Month) ..... (Day) 1905 (Year)

7. AGE: 15 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: George Brunt

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Clara Rascoit

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Geo Brunt

(Address) Ceily

15. Filed Nov 4 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on ..... 191... and that death occured on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Gun shot wound accidental

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos ..... ds.

(Signed) C E Dunwoody Coroner

8/30 1920 (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 9-3 1920

20. UNDERTAKER: C E Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V, S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2130
(No. ..... St.)

File No. 32187
Registered No. 171

1. PLACE OF DEATH.
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lovilla Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH. June (Month) 28 (Day) 1920 (Year)

7. AGE: ..... Yrs. 3 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Albert Brown

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Fruna Honeycutt

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Albert Brown
(Address) Idaho Falls

15. Filed Nov 6 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1920, to Oct 16 1920, that I last saw her alive on Oct 16 1920, and that death occured on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:

Acute Enteritis

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Bronchial Pneumonia

(Duration) ..... yrs. 1½ mos. ..... ds.

(Signed) J W Bell M. D.

10/17 1920 (Address) Idaho Falls Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 10/17 1920

20. UNDERTAKER: E E Dunwoody — ADDRESS: Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
File No. 32178
Registered No. 170

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Messerli
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Aug (Month) 5 (Day) 1919 (Year)

7. AGE: 1 Yrs. 1 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ✓
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jacob Messerli

11. BIRTHPLACE OF FATHER (State or Country): Switz

12. MAIDEN NAME OF MOTHER: Eliza Sealer

13. BIRTHPLACE OF MOTHER (State or Country): Switz

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Linwood
(Address) Idaho Falls

15. Filed Nov. 6 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 7th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Whooping Cough
(Duration) ..... yrs. ..... mos. 2 ds.
(Signed) W. P. Harris M. D.
9-7 1920 (Address) Idaho Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 9-7 1920

20. UNDERTAKER: C. E. Linwood — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

W. P. Harris

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32190

Registered No. 138

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 21V-0

(No. General Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alice Vera Porter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: January 12 1912 (Month) (Day) (Year)

7. AGE: 8 Yrs. 7 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Jos. Porter

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emma Seager

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. Porter

(Address) Victor Idaho

15. Filed Aug 19 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: August 18 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at 10:10 M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(Duration) ..... Yrs. ..... Mos. 10 ds.

Contributory (Secondary) Accidental

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C W Osborn M. D.

19..... (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 1 days. In the State 7 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Victor Idaho

Former or usual residence Victor Idaho

19. PLACE OF BURIAL OR REMOVAL: Victor Idaho

DATE OF BURIAL: Aug 20 1920

20. UNDERTAKER: Taylor-Edmondson

ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 32191
Registered No. 137

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls.
(No. Cleopatra Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Wallace Robinson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec. (Month) 1 (Day) 1919 (Year)

7. AGE: Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): Idaho.

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: David George Robinson

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Jessie Wallace

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David George Robinson
(Address) Idaho Falls

15. Filed Oct 10 1920. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 17 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 23, 1920 to Oct. 17, 1920
that I last saw him alive on Oct. 17, 1920
and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Pulmonis

(Duration) Yrs. 2 mos. — ds.
Contributory (Secondary) Bronchio Pneumonia & ileo-colitis
(Duration) Yrs. 1 mos. — ds.
(Signed) John O Miller M. D.
19 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 25 days. In the State ..... yrs. 11 mos. 17 days
Where was disease contracted if not at place of death? Rene Idaho.
Former or usual residence Idaho Falls.

19. PLACE OF BURIAL OR REMOVAL: Rosedale Cemetery
DATE OF BURIAL: Oct. 19 1920

20. UNDERTAKER: Taylor & Ericson Co.
ADDRESS: Idaho Falls.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 21 N^o

(No. ..... St.)

File No. 32102

Registered No. 134

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Gilbert S Brough

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	married

6. DATE OF BIRTH: January (Month) 21 (Day) 1890 (Year)

7. AGE: 30 Yrs. 9 Mos. ✓ ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: George F. Brough

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Minnie Snowball

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs S. D. Brough
(Address) Ucon, Ida

15. Filed Nov 6 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1920 to Oct 21 1920 that I last saw h[illegible] alive on Oct 21 1920 and that death occurred on the date stated above, at 7a M.

The CAUSE OF DEATH* was as follows:
General Peritonitis following
Operation for obstruction of small
Due to ruptured gangrenous appendix
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary) Chronic Nephritis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H K Hatch M. D.
Oct 22 1920 (Address) Idaho Falls.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ucon, Ida	10/24 1920

20. UNDERTAKER	ADDRESS
E E Dunwoody	Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 1005
File No. 32103
Registered No. 133

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME D A Campbell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: (Write the word) Married
6. DATE OF BIRTH: April 17th 1862 (Month) (Day) (Year)
7. AGE: 58 Yrs. 6 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Canada
10. NAME OF FATHER: Duncan Campbell
11. BIRTHPLACE OF FATHER (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Mary McCall
13. BIRTHPLACE OF MOTHER (State or Country): Scotland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Kate Eyering
(Address) Caldwell Ida
15. Filed Nov. 12 1920 John S. Imeyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 10 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1920 to Nov 10 1920
that I last saw him alive on Nov 10 1920
and that death occurred on the date stated above, at 3 30 P.M.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. 3 Hours ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M Kaley M. D.
11-13 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 11-13 1920
20. UNDERTAKER: E. F. Beckham ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 32194
Registered No. 136

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jessie D. Sutton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): single

6. DATE OF BIRTH: Dec (Month) 27 (Day) 1912 (Year)

7. AGE: 7 Yrs. 10 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. M. Sutton

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Effie Proud

13. BIRTHPLACE OF MOTHER (State or Country): Michigan

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. M. Sutton
(Address) Homedale, Ida.

15. Filed Nov. 16 1920 John L. Meyers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13 1920 to Nov 14 1920 that I last saw h[illegible] alive on Nov 14 1920 and that death occurred on the date stated above, at P. M.

The CAUSE OF DEATH* was as follows:
Peritonitis, (Ruptured Appendix)
..... (Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Coe M. D.
11/15 1920 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 11-16 1920

20. UNDERTAKER: J. Peckham ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 10 c
(No. ..... St.)

File No. 32196
Registered No. 138

1. PLACE OF DEATH
County of Canyon
City of Caldwell
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leslie Loyd Lemmon
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): single

6. DATE OF BIRTH: Dec (Month) 25 (Day) 1906 (Year)

7. AGE: 13 Yrs. 10 Mos. 23 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: J. A. Lemmon

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Maggie Sullen

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J A Lemmon
(Address) Caldwell, Ida

15. Filed Nov. 20 1920
John S. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1920 to Nov 18 1920
that I last saw h.. alive on Nov 18 1920
and that death occurred on the date stated above, at 11 P.M.
The CAUSE OF DEATH* was as follows:
Septic Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Ruptured appendix
(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) [illegible] M. D.
11/19 1920 (Address) Caldwell, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 11-20 1920

20. UNDERTAKER: [illegible] Peckham ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 22197
Registered No. 139

1. PLACE OF DEATH
County of Canyon
City of Caldwell,
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Blakey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Nov (Month) 24 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Henry Blakey.

11. BIRTHPLACE OF FATHER (State or Country): Minnesota.

12. MAIDEN NAME OF MOTHER: Elsie Siebert.

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Blakey.
(Address) Caldwell, Idaho

15. Filed Nov. 28 - 1920
John S. Reyes
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1920 to Nov 27 1920
that I last saw h[illegible] alive on Nov 25 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

premature Birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Gue M. D.
11/29 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Greenleaf Ida — DATE OF BURIAL: 11-28-1920

20. UNDERTAKER: C. V. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 9005
File No. 22198
Registered No. 140

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Amanda Estes Gilldan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): widow

6. DATE OF BIRTH: May (Month) 2 (Day) 1845 (Year)

7. AGE: 75 Yrs. 6 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House keeping
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): West Virginia

10. NAME OF FATHER: James M. Kee

11. BIRTHPLACE OF FATHER (State or Country): West Virginia

12. MAIDEN NAME OF MOTHER: Mary Knight

13. BIRTHPLACE OF MOTHER (State or Country): West Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jas M. Gilldan
(Address) Caldwell, Idaho

15. Filed Dec. 2 1920 John L. Meyer. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 20 1918, to Nov 29 1920 that I last saw h.er alive on Nov 20 1920 and that death occurred on the date stated above, at 9-45 M.

The CAUSE OF DEATH* was as follows: Cancer Uterus

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Somers M. D.

11/30 1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	Dec 2 1920

20. UNDERTAKER	ADDRESS
E V Peckham	Caldwell

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No.
File No. 32200
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elnora Rutledge
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Aug (Month) 18 (Day) 1881 (Year)

7. AGE: 39 Yrs. 2 Mos. 25 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Samuel Hall

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Eliza McCuan

13. BIRTHPLACE OF MOTHER (State or Country): not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred L Rutledge
(Address) Emmett Idaho

15. Filed 12/6 1920 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) — 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 10th 1920, to Nov. 13th 1920, that I last saw h[illegible] alive on Nov. 13th 1920, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:
Shock following operation

(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Thos E. Maguire M. D.
Nov 13 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida. DATE OF BURIAL 19

20. UNDERTAKER: C. Buckmun ADDRESS: Emmett Idaho

FORM V. S. No. 5-95 M. 1-19.

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 1005
File No. 32201
Registered No. 143

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emily Luce Lord

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married

6. DATE OF BIRTH: Nov. (Month) 20 (Day) 1847 (Year)

7. AGE: 73 Yrs. — Mos. 20 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Maine

10. NAME OF FATHER: Columbus Harvey

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Mary A. Daggett

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): H. Lee Lord
(Address): Wilder Ida.

15. Filed Dec. 11 — 1920 John U. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1920 to Dec 10 1920
that I last saw her alive on Dec 9 1920
and that death occurred on the date stated above, at 4 a. M.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) ..... Yrs. 2 mos. 5 ds.
Contributory (Secondary): Nephritis
(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) C. W. Talley M. D.
12-10-1920 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill. DATE OF BURIAL: 12-11-1920

20. UNDERTAKER: C. N. Peckham ADDRESS: Caldwell

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 1007
(No. ..... , ... St.)

File No. 32202
Registered No. 19

1. PLACE OF DEATH.
County of Canyon
City of Parma
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
F	W	M (Write the word.)

6. DATE OF BIRTH.
Sept (Month) 11 (Day) 1857 (Year)

7. AGE
63 Yrs. 2 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Kentucky

10. NAME OF FATHER
Thomas Blackwell

11. BIRTHPLACE OF FATHER
(State or Country) Ky.

12. MAIDEN NAME OF MOTHER
Margaret Dills

13. BIRTHPLACE OF MOTHER
(State or Country) Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Katie M. Williams
(Address) Parma Ida

15.
Filed Nov 6 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Nov 4 1920,
that I last saw her alive on Nov 1 1920,
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) W. M. Mitchell M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~	DATE OF BURIAL
Parma Ida	Nov 6 1920
20. UNDERTAKER	**ADDRESS**
Beckham Funeral	Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2007
(No. ..... St.)

File No. 32203
Registered No. 98

1. PLACE OF DEATH.
County of Canyon
City of Parma
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Loretta Irene Truman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): M

6. DATE OF BIRTH. Jan (Month) 10 (Day) 1885 (Year)

7. AGE: 35 Yrs. 10 Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Nelson Allen

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Sarah Falor

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Lynch
(Address) Parma Ida

15. Filed 12-1 1920 Luhrkaldt Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 19 1920, to Nov. 29 1920, that I last saw h.is alive on Nov. 29 1920, and that death occured on the date stated above, at 4 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Pulmonary Stitches
(Duration 1 yrs. ..... mos. ..... ds.
(Signed) W. W. Hitchcock M. D.
12/1 1920 (Address) Parma

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Parma — DATE OF BURIAL: Dec 1 1920

20. UNDERTAKER: Parkhurst Fur Co — ADDRESS: Parma

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2056
File No. 32204
Registered No.

1. PLACE OF DEATH

County of Canyon
~~City of~~ Melba
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Gideon Murphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1920 (Year)

7. AGE: 2 Yrs. 2 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Parma, Idaho

10. NAME OF FATHER: George Murphy

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Della Laverda Barr

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Murphy
(Address)

15. Filed NOV. 14 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 2 1920 to Nov. 12 1920, that I last saw him alive on Nov. 12 1920, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH was as follows:

Ileo Colitis

(Duration) 1 Yrs. 5 mos. 14 ds.

Contributory (Secondary) Oedema of Lungs

(Duration) 1 yrs. 1 mos. 1 ds.

(Signed) Samuel A Swayne M. D.

11-13 1920 (Address) Melba Id.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Melba Idaho
DATE OF BURIAL: Nov. 14 1920

20. UNDERTAKER: None
ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 805
File No. 32207
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. 2 Madison Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wenzel Wasel
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 28 (Day) 1852 (Year)

7. AGE: 68 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bohemia

10. NAME OF FATHER: Titus Wasel

11. BIRTHPLACE OF FATHER (State or Country): Bohemia

12. MAIDEN NAME OF MOTHER: ~

13. BIRTHPLACE OF MOTHER (State or Country): Bohemia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Wasel
(Address) Nampa Ida

15. Filed Dec. 10 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 23 1920, to Nov. 23 1920, that I last saw h alive on Nov 23 1920, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
General debility
Arterio-sclerosis Hypocardia
(Duration) Yrs. 8 mos. ds.
Contributory (Secondary) Scoliosis from trauma-
atism (Duration) 20 yrs. mos. ds.

(Signed) Geo R Proctor M. D.
Nov 25, 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lohrdawn Cem — DATE OF BURIAL: Nov. 25 1920

20. UNDERTAKER: C. K. Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 32209
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. 512 - 14th Ave N St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Winona Carpenter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX fem

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Nov 8 1920
(Month) (Day) (Year)

7. AGE — Yrs. — Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER M. W. Carpenter

11. BIRTHPLACE OF FATHER (State or Country) Neb

12. MAIDEN NAME OF MOTHER Eloise Matteson

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M W Carpenter

(Address) Nampa Ida

15. Filed Dec 8 1920 Pearle Dodds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1920, to Dec 8 1920, that I last saw her alive on Dec 7 1920, and that death occurred on the date stated above, at 6 a. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ... Yrs. ... mos. 3 ds.

Contributory (Secondary) ✓

(Duration) ... Yrs. ... mos. ... ds.

(Signed) Marion L. Tyree M. D.

Dec 9 1920 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Herman Nebraska — **DATE OF BURIAL** 12 - 1920

20. UNDERTAKER F K Robinson — **ADDRESS** Nampa Ida

7

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32210
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
Registration District No. 7
Primary Registration District No. 1852
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Rudge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: ~~Feb~~ Feb 21 (Month) (Day) 1851 (Year)

7. AGE: 69 Yrs. 8 Mos. 27 ~~28~~ ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Builder and contractor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Gloucestershire England

10. NAME OF FATHER: Henry Rudge

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Susan

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Rudge Jr
(Address) Nampa Idaho

15. Filed Dec 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-7 1920, to 11-17 1920, that I last saw ~~him~~ alive on 11-17 1920, and that death occurred on the date stated above, at 3.30 A.M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) Yrs. mos. 7 ds.
Contributory (Secondary) Arteriosclerosis
(Duration) about 1 yrs. mos. ds.
(Signed) H C Robinson M. D.
11-19 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem — DATE OF BURIAL: 11-21 1920

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

(No. 576 6th Ave So Str.)

File No. 2211

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Albert P Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH

Sept (Month) 23 (Day) 1891 (Year)

7. AGE

29 Yrs. 2 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Tenn

10. NAME OF FATHER John Jones

11. BIRTHPLACE OF FATHER (State or Country) Virginia

12. MAIDEN NAME OF MOTHER Hannah Simmons

13. BIRTHPLACE OF MOTHER (State or Country) Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X Johan Jones

(Address) Nampa Ida

15.

Filed Dec. 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1920, to Dec 4 1920 that I last saw h.im alive on Dec 3 1920 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Septicemia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) acute arthritis

(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) Leo W. Chilton M. D.

12/6 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	12-6 1920

20. UNDERTAKER	ADDRESS
Fred K Robinson	Nampa Ida

Chilton.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
(No. ..... , ... St.)
File No. 32212
Registered No. .....

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas B. Lance
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Apr (Month) 17 (Day) 1859 (Year)

7. AGE: 61 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R.R. Patrolman
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Georgia

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Lance
(Address) Nampa Ida

15. Filed Dec 10 1920 Pearl Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1920, to Dec 7 1920 that I last saw him alive on Dec 7 1920 and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach
& rectum

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Murray M. D.
12/7 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida.	12-8 1920
20. UNDERTAKER	ADDRESS
Fred K. Robertson	Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1554
File No. 32213
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James H Merrett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1852 (Year)

7. AGE: 68 Yrs. Mos. 25 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumbermen
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER: W W H. Merrett

11. BIRTHPLACE OF FATHER (State or Country): Kenn

12. MAIDEN NAME OF MOTHER: Martha Sides

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Don Merrett
(Address) Nampa Ida

15. Filed DEC. 10 1920 Pearle Dodder Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1920 to Nov 22 1920 that I last saw him alive on Nov 21 1920 and that death occurred on the date stated above, at 1230 M.

The CAUSE OF DEATH* was as follows:

Coma from diabetes

(Duration) X Yrs. X mos. 2 ds.

Contributory (Secondary) Diabetes

(Duration) about 4 yrs. X mos. X ds.

(Signed) H R Sheldon M. D.

11/22 1920 (Address) Nampa 2nd Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerdawn — DATE OF BURIAL: 11-23 1920

20. UNDERTAKER: Fred K. Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 32214
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. 1022 R.R. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH: Nov (Month) 27 (Day) 20 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or 3 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: V
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Spurlock

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mabel E. Rankin

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Spurlock
(Address) Nampa Ida

15. Filed Dec. 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Infant Spurlock Nov. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27 1920, to Nov. 27 1920, that I last saw him alive on Nov. 27 1920, and that death occurred on the date stated above, at 7:30 A.M.

The CAUSE OF DEATH* was as follows:
Atelectasis

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary): Prematurity
(Duration) ... yrs. ... mos. ... ds.

(Signed) Geo. A. Proctor M. D.
Nov. 27 1920 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kohlerlawn Cem. DATE OF BURIAL: 11-27 1920

20. UNDERTAKER: F K Robinson ADDRESS: Nampa Ida

BYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 17
Primary Registration District No. 1506
File No. 32215
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella K. Egbert
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	white	Married

6. DATE OF BIRTH: Oct (Month) 5 (Day) 1857 (Year)

7. AGE: 63 Yrs. 1 Mos. 22 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N York

10. NAME OF FATHER: Wisner Kinne

11. BIRTHPLACE OF FATHER (State or Country): N.Y.

12. MAIDEN NAME OF MOTHER: Minerva Stone

13. BIRTHPLACE OF MOTHER (State or Country): N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Egbert
(Address) Nampa Ida

15. Filed Dec. 18 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1920 to Nov. 26 1920 that I last saw her alive on Nov. 26 1920 and that death occurred on the date stated above, at 8 a. M.

The CAUSE OF DEATH* was as follows:
Paralytic Stroke
Paraplegia

(Duration) Yrs. mos 6½ ds.
Contributory (Secondary): Not known
(Duration) yrs. mos. ds.

(Signed) J. H. Murray M. D.
12/1 1920 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 11/29 19 20

20. UNDERTAKER: Buck Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 32216
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME: Glenn L. Everett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 22 (Day) 1920 (Year)

7. AGE: 0 Yrs. 3 Mos. 23 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: E. R. Everett

11. BIRTHPLACE OF FATHER (State or Country): Colo.

12. MAIDEN NAME OF MOTHER: Georgia Huston

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E. R. Everett
(Address): Nampa Ida

15.
Filed Dec. 10 1920 Pearle Dodds
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1920 to — 19..., that I last saw h— alive on — 19..., and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:
Child found dead in crib in the Morning. Cause of death unknown.
(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J. H. Murray M. D.
11/16 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pohlenkamp Cem	11-15-1920
20. UNDERTAKER: Fred T. Robinson	ADDRESS: Nampa

BYNE-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 32217
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.
(No. , St.)

2. FULL NAME Loyd O McMichael
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 14 (Day) 1918 (Year)

7. AGE: 2 Yrs. 6 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. L. McMichaels

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mary Carmady

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. McMichaels
(Address) Nampa, Ida.

15. Filed Dec 18 1920 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1920, to Nov 27 1920.
that I last saw him alive on Nov 27 1920.
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH was as follows:

Typhoid Fever

(Duration) Yrs. mos. 14 ds.
Contributory (Secondary)
(Duration) — yrs. — mos. — ds.

(Signed) M J [illegible] M. D.
Dec 1 1920 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	11-29 1920
20. UNDERTAKER	ADDRESS
Fred K Robinson	Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32218
Registered No. 18

1. PLACE OF DEATH.
County of Canyon
City of Parma
Registration District No.
Primary Registration District No. 2007
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Walter Robert McNees

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): S.

6. DATE OF BIRTH. Aug (Month) 14 (Day) 1920 (Year)

7. AGE: 2 Yrs. 2 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canyon Co

10. NAME OF FATHER Ben H. McNees

11. BIRTHPLACE OF FATHER (State or Country) Tenn

12. MAIDEN NAME OF MOTHER Florence Morrison

13. BIRTHPLACE OF MOTHER (State or Country) Colo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Ben H McNees
(Address) Parma Ida

15. Filed Oct. 15 1920 Ludlow Aldrich Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ last deceased ~~from~~ Oct. 14 1920, to ..... 191..., that I last saw h. alive on Oct 14 1920 and that death occured on the date stated above, at 12 20 a. M.

The CAUSE OF DEATH* was as follows:
"Starvation - might be called "mal-nutrition" - due to improper nourishment.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. D. Chambers M. D.
Oct 15 1920 (Address) Parma, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL ~~OR REMOVAL~~ Parma Ida — DATE OF BURIAL Oct 17 1920

20. UNDERTAKER Peckham Fun Co — ADDRESS Parma

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2048
File No. 22219
Registered No. 17

1. PLACE OF DEATH
County of Caribou
City of Soda Springs
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ueda Hauerwas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
female	White Caucasian	Married (Write the word.)

6. DATE OF BIRTH: January 27 1883 (Month) (Day) (Year)

7. AGE: 37 Yrs. 9 Mos. 0 ds. 20
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Oxford Idaho

10. NAME OF FATHER: Lee Merrick

11. BIRTHPLACE OF FATHER (State or Country): Franklin Utah

12. MAIDEN NAME OF MOTHER: Frances H Henderson

13. BIRTHPLACE OF MOTHER (State or Country): Brigham City Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frances Merrick
(Address) Lava Hot Springs Ida

15. Filed Nov 8 1920 Eric Hackleman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 7, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 6 1920 to Nov 7 1920
that I last saw h.x alive on Nov 7 1920
and that death occurred on the date stated above, at 6:30 A.M.
The CAUSE OF DEATH* was as follows:
Suppression of Urine
(Duration) ..... Yrs. 0 mos. 1 ds.
Contributory (Secondary) Uremia Poisoning
(Duration) 3 yrs. ..... mos. ..... ds.
(Signed) Eric Hackleman M. D.
Nov 8 1920 (Address) Soda Springs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lava Hot Springs	..... 19.....
20. UNDERTAKER: Schumacher & Hall	ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-12 M. 6-15-17.

Transit.

CERTIFICATE OF DEATH 32220

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 427
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. 122 N. Oakley Ave. St.)

2. FULL NAME John Lowe

WRITE PLAINLY, WITH UNFADING INK—THIS CERTIFICATE BECOMES A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed
6. DATE OF BIRTH: March (Month) 23 (Day) 1852 (Year)
7. AGE: 68 Yrs. 7 Mos. 1 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Stock Grower
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): England
10. NAME OF FATHER: John Lowe
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Unknown
13. BIRTHPLACE OF MOTHER (State or Country): England
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. J. Lowe
(Address) Burley Ida
15. Filed Nov. 10, 1920 Dr. J. C. Patten Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 4 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Sep 28 1920 to Oct 24 1920 that I last saw him alive on Oct 24 1920 and that death occurred on the date stated above, at 5:10 P. M.
The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage
(Duration) — Yrs. — mos. — ds.
Contributory (Secondary) none
(Duration) — Yrs. — mos. — ds.
(Signed) Joseph Trempleau M. D.
19 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days, In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Oct 7 1920
20. UNDERTAKER: L. B. Talbot. ADDRESS: Burley Ida.

FORM V. S. No. 5-12 M. 6-15-17.

32221 Carter

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. .....
Registered No. 45.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2196
(No. ....., ... St.)

2. FULL NAME Mabel Lavon Martindale

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 5 (Day) 1920 (Year)

7. AGE ... Yrs. ... Mos. 13 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. C. Martindale

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ida Lee

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): J. C. Martindale
(Address): Burley Ida

15. Filed Nov. 16, 1920
H. J. Patton
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 11 1920 to Oct 17 1920 that I last saw her alive on Oct 17 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Erysipelas

(Duration) ... Yrs. ... mos. 7 ds.

Contributory (Secondary)

(Duration) ... Yrs. ... mos. ... ds.

(Signed) J. W. Carter M. D.
19.... (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pleasant View Cemetery — DATE OF BURIAL: Oct 19 1920

20. UNDERTAKER: Leverett — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

32222

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 456
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. R.F.D. # 2 St.)

2. FULL NAME Ingrid Pearson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write word.): Widowed

6. DATE OF BIRTH. June (Month) 21 (Day) 1852 (Year)

7. AGE: 68 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Lars Oleson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Kerstin Larson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carolina Johnson
(Address) R.F.D. # 2 Burley Ida.

15.
Filed Oct 20 1920 W. J. C. Pattman
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Oct (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1920 to Oct 27 1920
that I last saw h.. alive on Oct 27 1920
and that death occurred on the date stated above, at 7.00 P. M.

The CAUSE OF DEATH* was as follows:
Typhoid Fever
(Duration) Yrs. mos. 20 ds.
Contributory (Secondary)
(Duration) Yrs. mos. ds.
(Signed) P. W. Storey M. D.
19.... (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Murray Utah.
DATE OF BURIAL: Oct 29 1920

20. UNDERTAKER: L. B. Bellogy
ADDRESS: Burley Ida.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 58 d
Primary Registration District No. 2138
(No. ..... St.)

File No. 32223
Registered No. .....

1. PLACE OF DEATH
County of Camas
City of Soldier
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma S. Reed
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	white	married

6. DATE OF BIRTH: December (Month) 25 d (Day) 1865 (Year)

7. AGE: 54 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Mr. Friedman

11. BIRTHPLACE OF FATHER (State or Country): U.S-

12. MAIDEN NAME OF MOTHER: Nancy Dougherty

13. BIRTHPLACE OF MOTHER (State or Country): US

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Reed.
(Address) Soldier, Idaho.

15. Filed Dec. 9 19 20 — L Wilencheck, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 4 th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1st 19 20, to Nov 4th 19 20, that I last saw h[illegible] alive on Nov 4th 19 20, and that death occurred on the date stated above, at 2:00 P.M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L Wilencheck M. D.
Nov 8 19 20. (Address) Fairfield, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Soldier, Idaho — DATE OF BURIAL: Nov 6 d 19 20

20. UNDERTAKER — ADDRESS

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32224

Registered No. 49

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 2168

County of Clearwater

City of Orofino (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Rickert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: About (Month) (Day) 1860 (Year)

7. AGE: 60 yrs. mos. ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Ida.

15. Filed Nov 8 1920 J. M. Faile Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) First (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 13 1920, to Oct. 1st 1920; that I last saw h im alive on Oct 1st 1920 and that death occurred on the date stated above, at 2:20 P. M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis.

(Duration) ? yrs. mos. ds.

Contributory (Secondary) Insanity

(Duration) ? yrs. mos. ds.

(Signed) John W. Greene M. D.

Oct 1st 1920 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 49 days. ?

In the State ..... yrs. ..... mos. ..... days. ?

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: The Northern Idaho Sanitarium Cemetery

DATE OF BURIAL: Oct. 4th 1920

20. UNDERTAKER: P. M. Johnson

ADDRESS: Grave #6 Row #4 of New addition Orofino, Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2165
File No. 32225
Registered No. 50

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wilhelma Mottler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Female	White	Widow

6. DATE OF BIRTH: July (Month) 8th (Day) 1844 (Year)

7. AGE: 76 yrs. 3 mos. 22 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Formerly Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): House work

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho.

15. Filed Oct 31 1920 J. M. Tansy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 30th (Day) 1920 ~~191~~ (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 20 1920 ~~191~~, to Oct. 30th 1920 ~~191~~, that I last saw her alive on Oct. 29th ~~191~~ 1920 and that death occurred on the date stated above, at 12:15 A.M.

The CAUSE OF DEATH* was as follows:
Arteric Sclerosis
?
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
?
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John A. Givens M. D.
Oct 30 1920 (Address) Orofino Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. Eleven Days ds. In the State 4 yrs. ..... mos. ..... ds.
Where was disease contracted if not at place of death? ?
Former or usual residence Rose Lake, Idaho

19. PLACE OF BURIAL OR REMOVAL: Rose Lake Idaho | DATE OF BURIAL 191

20. UNDERTAKER: C. E. Bolo and Son | ADDRESS Orofino Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

32226

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 71
Registered No. 51

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles Hatter

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: About 1843
(Month) (Day) (Year)

7. AGE: 77 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Blacksmith.
(b) General nature of industry business, or dstablishment in which employed (or employer): Horseshoeing, Etc.

9. BIRTHPLACE (State or Country): In Kentucky at Covington

10. NAME OF FATHER: ?

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho

15.
Filed Nov 8 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October 31st 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27th 1920, to Oct. 31st 1920, that I last saw him alive on October 31st 1920 and that death occurred on the date stated above, at 10:00 A.M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
?
(Duration) ? yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) ? yrs. ..... mos. ..... ds.

(Signed) John W Stevens M. D.
Oct. 31 1920. (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 4 mos. 4 days. In the State Over 40 years ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? ?
Former or usual residence Riggins, Idaho.

19. PLACE OF BURIAL OR REMOVAL: Grave #7 4th Row New add. The Northern Idaho Sanitarium
DATE OF BURIAL: 11/2 1920

20. UNDERTAKER: Owen Devlin
ADDRESS: Orofino, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 32227
Registered No. 52

1. PLACE OF DEATH
County of Clearwater
City of Orofino (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George B. Weston
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Wid (Write the word.)

6. DATE OF BIRTH: Mar 19 (Month) (Day) 1838 (Year)

7. AGE: 92 Yrs. 7 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. B. Weston
(Address) Orofino Idaho

15. Filed Nov 9 1920
J. McDaniel
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 8 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1916, to Nov 8 1920
that I last saw him alive on Nov 8 1920,
and that death occurred on the date stated above, at 6:30 P.M.
The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(Duration) ? Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arteriosclerosis
(Duration) ? yrs. ..... mos. ..... ds.

(Signed) J. McDaniel M. D.
Nov 9 1920 (Address) Orofino Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Idaho
DATE OF BURIAL: Nov 10 1920

20. UNDERTAKER: Orofino Undertaking Co
ADDRESS: Orofino Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 368
File No. 22228
Registered No. 32

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry H Bole

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	married

6. DATE OF BIRTH: Jan (Month) 1 (Day) 1857 (Year)

7. AGE: 69 Yrs. 11 Mos. 15 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Doctor
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: William Bole

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Bole
(Address) Orofino Idaho

15. Filed Nov 16 1920 J. H. Hardy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1918 to Nov 15 1920
that I last saw him alive on Nov 15 1920
and that death occurred on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:
Degeneration of Spinal Cord
Chronic nephritis & Hypostatic
cystitis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) E W Hoagland M. D.
Nov 16 1920 (Address) Orofino Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Idaho	Nov 17 1920
20. UNDERTAKER	**ADDRESS**
C & Bob and Sons	Orofino Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168
(No. ..... St.)

File No. 32229
Registered No. 1
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William Smith

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Divorced

6. DATE OF BIRTH
(Month) ✓ (Day) ✓ 1855 (Year)

7. AGE
65 yrs. ✓ mos. ✓ ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Rancher
(b) General nature of industry business, or dstablishment in which employed (or employer) Farming & stock raising

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho,

15.
Filed Nov 16 1920
J. M. Tarbet
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH November Fifteenth 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1920 to Nov. 15 1920 that I last saw h[illegible] alive on Nov. 15 1920 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
?
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
(Duration) ? yrs. ..... mos. ..... ds.
(Signed) Johnson Clements M. D.
Nov 15 1920 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ✓ yrs. 1 mos. 19 days. In the State 32 ✓ yrs. ✓ mos. ..... days.
Where was disease contracted if not at place of death? ?
Former or usual residence Linfor, Shoshone County, Idaho,

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Orofino Idaho	Nov 20 1920

20. UNDERTAKER	ADDRESS
C. E. Bobo and Son	Orofino Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32230

Registered No. V V

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

Registration District No. 90

Primary Registration District No. 7168

County of Clearwater

City of Orofino (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth Ashart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	?

6. DATE OF BIRTH

..... (Month) ..... (Day) 1 (Year)

7. AGE

..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION ?

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) ?

9. BIRTHPLACE ? (State or Country)

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER ? (State or Country)

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER ? (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. W. Atteberry

(Address) Orofino, Idaho.

15. Filed Dec 1, 1920 J. M. Furey Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

November (Month) 16th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 28 1913, to Nov. 16th 1920, that I last saw her alive on Nov. 15th 1920, and that death occurred on the date stated above, at 7:15 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

?

(Duration) 1 yrs. ..... mos. ..... ds.

Contributory .....

(Secondary) ?

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Stevens M. D.

Nov 16 1920 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death 7 yrs. 7 mos. 19 days. In the State Over 7 yrs. 7 mos. 19 days

Where was disease contracted if not at place of death? ?

Former or usual residence Bonner County, Idaho

19. PLACE OF BURIAL OR REMOVAL The Northern Idaho Cemetery New | DATE OF BURIAL Nov. 18. 1920

20. UNDERTAKER Ladd & Shaw Box 4, Orofino | ADDRESS

J. W. Atteberry

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 35

County of Elmore — Primary Registration District No. 2021 — File No. 22231

City of Glenn's Ferry — (No. ....., ... St.) — Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Andrew Burton

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: March 20 (Month) (Day) 1861 (Year)

7. AGE: 59 yrs. 8 mos. 1 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Boilermaker Helper
(b) General nature of industry business or establishment in which employed (or employer): O.S.L.R.R.

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Samuel Burton

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: May Roffuis

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Mary Burton
(Address) Glenn's Ferry Idaho

15.
Filed Nov 23 1920 — J. W. Davis — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 21st 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 21st 1920, to Nov. 21st 1920, that I last saw him alive on Nov. 21st 1920, and that death occurred on the date stated above, at 9:50 P.M.

The CAUSE OF DEATH* was as follows:
Angina Pectoris
..... (Duration) ..... yrs. ..... mos. 3 hrs ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.
Nov 23 1920 (Address) Glenn's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mountain Home Idaho — DATE OF BURIAL: Nov. 24 1920

20. UNDERTAKER: Joe Rubbam — ADDRESS: Glenn's Ferry Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & RINDERS. BOISE 16672

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 22233

Registered No. 73

1. PLACE OF DEATH.

County of Franklin

City of Dayton

(No. ....., ... St.)

Registration District No. 27

Primary Registration District No. 2119.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Page

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 11 (Day) 1 (Year)

7. AGE: 53 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Kemp

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Phillis Green

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James Page

(Address)

15. Filed Nov 22 1920 Dora Rudd Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 24 1920, to Sept 30 1920, that I last saw h[er] alive on Sept 30 1920 and that death occured on the date stated above, at 5a M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis following Interlobular abscess preceding Lobar Pneumonia

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) Anemia, Intestinal nephritis

(Duration) yrs. 7 mos. ds.

(Signed) Curtis Rudd M. D.

11/17 1920 (Address) Preston Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dayton Ida — DATE OF BURIAL: 11/19 1920

20. UNDERTAKER: W. A. Skidmore — ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 32234
Registered No. 76

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Verl Matsumoto
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Aug (Month) 9 (Day) 1920 (Year)

7. AGE: Yrs. 3 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Preston Ida

10. NAME OF FATHER: George Matsumoto

11. BIRTHPLACE OF FATHER (State or Country): Japan

12. MAIDEN NAME OF MOTHER: Julia Cafferty

13. BIRTHPLACE OF MOTHER (State or Country): Fairview Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julia Matsumoto
(Address) Preston

15. Filed 1/22 1920 D. A. Rudd Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: NOV (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from NOV. 5, 1920, to NOV. 10 1920 that I last saw h... alive on NOV. 9 1920, and that death occurred on the date stated above, at 2:00 A M.
The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — Yrs. — mos. 5 ds.
Contributory (Secondary) —
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. States M. D.
NOV. 10 1920. (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston | DATE OF BURIAL: Nov. 11 1920

20. UNDERTAKER: W. A. Redmore | ADDRESS: Preston

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119.
(No. .... St.)

File No. 32235
Registered No. 77

1. PLACE OF DEATH.
County of Franklin
City of Preston
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Polly M. Packer

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Mar. (Month) 15 (Day) 1833 (Year)

7. AGE: 87 Yrs. 8 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Moses Mecham

11. BIRTHPLACE OF FATHER (State or Country): Grafton Co New Hampshire

12. MAIDEN NAME OF MOTHER: Elvira Derby

13. BIRTHPLACE OF MOTHER (State or Country): Grafton New Hampshire

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Packer
(Address) Preston Idaho

15.
Filed 11/22 1918 D. A. Crull, Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 17 (Day) 1918 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14 1918, to Nov. 17 1918, that I last saw her alive on Nov. 15 1918, and that death occured on the date stated above, at 3-20 P.M.
The CAUSE OF DEATH* was as follows:
No Followed Cause-Test
Renies Decomp.
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Allen R. Gaulty M. D.
19 ..... (Address) Preston Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Franklin Ida
DATE OF BURIAL: Nov. 19 1918

20. UNDERTAKER: W. A. Skidmore
ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 12256
Registered No. 75

1. PLACE OF DEATH
County of Franklin Lee
City of Preston
(No. ..... St.)
Registration District No. 27
Primary Registration District No. 2119.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Foster

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 22 (Day) 1882 (Year)

7. AGE: 37 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: assistant
(b) General nature of industry, business or establishment in which employed (or employer): in Lumber yard

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: George W. Foster

11. BIRTHPLACE OF FATHER (State or Country): U. S. A

12. MAIDEN NAME OF MOTHER: Laura Boylan

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mabel Foster Wendreck
(Address) Wilder Idaho

15. Filed 11/22 1920. Dr A R Pulte
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 9 1920 to Nov. 11 1920 that I last saw him alive on Nov. 11 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Pleurisy with Pneumonia
Lobar -

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Trad Cancer
(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) A R Pulte M. D.
11/22 1920 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Preston

19. PLACE OF BURIAL OR REMOVAL: Preston — DATE OF BURIAL: 11/25 1920

20. UNDERTAKER: G A Lundquist — ADDRESS: Logan Utah

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32237

Registered No.

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH

County of

City of

(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harriet Elizabeth Drollinger

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 5 (Day) 1864 (Year)

7. AGE: 56 Yrs. Mos. 9 ds. 24

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Alonzo Nay

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Hannah Huggin

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Drollinger
(Address) ashton Idaho

15. Filed 11-30 1920 C. A. Madsen Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to Jan 29 1920, that I last saw her alive on Jan 29 1920, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Lagrippe Pneu & Failure

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary) Cardiac Stenosis Gastr

(Duration) yrs. mos. ds.

(Signed) L. P. Hagan M. D.

Nov 30 1920 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ashton Idaho — DATE OF BURIAL: 12-2 1920

20. UNDERTAKER: Lewis Riser — ADDRESS: Ashton Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 6
File No. 22238
Registered No. ____

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel A. Chidester
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widower (Write the word.)

6. DATE OF BIRTH: Feb 16 (Month) (Day) 1860 (Year)

7. AGE: 60 Yrs. 8 Mos. 15 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Teacher
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer Hess
(Address) Emmett Ida

15.
Filed 11/10 1920
J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1920, to Oct 31 1920
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Chronic Myocarditis.
Was dead when I saw him
(Duration) seven yrs. ____ mos. ____ ds.
Contributory (Secondary) ____
(Duration) ____ yrs. ____ mos. ____ ds.
(Signed) R N Cummings M. D.
11/1 1920 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL: 11/9 1920
20. UNDERTAKER: C. D. Bucknum
ADDRESS: Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 6
Primary Registration District No.
File No. 6239
Registered No.

1. PLACE OF DEATH
County of Gem
City of Emmett
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Son of A. J. Godsey
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Oct (Month) 31 (Day) 1920 (Year)

7. AGE: new Born Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: A. J. Godsey

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: Betty Reed

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Godsey
(Address) Emmett Idaho

15. Filed 11/10 1920 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1920, to Oct 31 1920 that I last saw h[illegible] alive on Oct 31 1920 and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:
Intoxication caused from smallpox in utero.

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) R. B. Cummings M. D.
11/1 1920 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Ida — DATE OF BURIAL: 11/1 1920

20. UNDERTAKER: O. C. Bucknum — ADDRESS: Emmett Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 32240
Registered No. .....

1. PLACE OF DEATH
County of Elmore
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mervin L. Hawthorn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: July (Month) 8th (Day) 1864 (Year)

7. AGE: 56 Yrs. 5 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real estate Dealer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon. Yamhill Co.

10. NAME OF FATHER: Noah Hawthorn

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Jennie Hill

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Stella Hawthorn
(Address) Emmett Idaho

15. Filed 12/6 1920
J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 7 1920 to Dec 4 1920
that I last saw h[illegible] alive on Dec 4 1920
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Miliar[illegible] tuberculosis
unknown
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Benton O. Clark M. D.
Dec 6 1920 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mercer Idaho
DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: O. L. Buckmeun
ADDRESS: Emmett Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 49
Primary Registration District No. 3421
(No. ....., ... St.)

File No. 32241
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Harrisburg
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Louise Hanvey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. May (Month) 15 (Day) 1852 (Year)
7. AGE: 68 Yrs. 6 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.
8. OCCUPATION
(a) Trade, profession or particular kind of work... housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Missouri
10. NAME OF FATHER David B. Common
11. BIRTHPLACE OF FATHER (State or Country) Indiana
12. MAIDEN NAME OF MOTHER Margaret Bowers
13. BIRTHPLACE OF MOTHER (State or Country) Ogden
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C. C. Hanvey
(Address) Woodland Ida
15. Filed 11/24 1920 C J Johnson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7 1920, to Nov 22 191..., that I last saw h.s alive on Nov 22 191..., and that death occured on the date stated above, at 11 PM.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia fever
.....(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary)
.....(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C J Grayson M. D.
11.23.1920 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Woodland Idaho — DATE OF BURIAL 11/24 1920

20. UNDERTAKER C J Johnson — ADDRESS Kamiah Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

32242

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 105

County of Idaho

Primary Registration District No. 2183

File No. 30

City of Precinct of Kentonville (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernardina Uhlenkotte

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: June 10th 1872 (Month) (Day) (Year)

7. AGE: 48 yrs. 5 mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sister of the OSB
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: John Uhlenkott Sen.

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Gertrud Uhling

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gerhard Uhlenkott
(Address) Kentonville Ida.

15.
Filed Nov 29 1920 H W Blake
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
November 29 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 1917, to Nov 29 1920 that I last saw her alive on Nov 15 1920, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Cirrhosis of liver
.....
.....
(Duration) 1 yrs. ..... mos. ..... ds.
Contributory (Secondary) Automobile Accident
(Duration) 2 yrs. — mos. ..... ds.

(Signed) J D Shinnick M. D.
Nov 29 1920 (Address) Cottonwood Ida Co.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: St Gertrudes Private Cemetery Kentonville
DATE OF BURIAL: Dec 1st 1920

20. UNDERTAKER: Rev Father James, O.S.B.
ADDRESS: Cottonwood Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

22243

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 105
Primary Registration District No. 2183
File No. 29
Registered No.

1. PLACE OF DEATH
County of Idaho
City of Perdemand (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sophia Kaus
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec^r (Month) 29 (Day) 1890 (Year)

7. AGE: 29 Yrs. 10 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Peter Kaus

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Sophia Weitzel

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. J. Pollock
(Address) Perdemand Idaho.

15. Filed Nov 23 19.....
H B Blake
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1920, to Nov 1 1920 that I last saw her alive on Sept 2 1920 and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:

Starvation (Natural)
Unknown.
(Duration) 1 yrs. 3 mos. ds.
Contributory (Secondary) Stricture following Stabbing
Conjunctivitis Eye
(Duration) yrs. mos. ds.

(Signed) Wesley F. Orr M. D.
Nov 27 1920 (Address) Cottonwood Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Perdemand
DATE OF BURIAL: 11/24 1920

20. UNDERTAKER: Amil Renggli.
ADDRESS: Perdemand

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32244

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Idaho

City of Grangeville (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 103

Primary Registration District No. 2161

File No. .....

Registered No. 35

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Leslie Twilliger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct 17 (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. 1 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank Leslie Twilliger

11. BIRTHPLACE OF FATHER (State or Country) Minn.

12. MAIDEN NAME OF MOTHER Ruby Smith

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leslie Twilliger

(Address) Grangeville

15. Filed Dec 7 1920 G S Stockton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1919, to Nov 17 1920 that I last saw him alive on Sept 10 1920 and that death occurred on the date stated above, at 7, P. M.

The CAUSE OF DEATH* was as follows:

Transition

(Duration) since birth Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. S. Stockton M. D.

10/18 1920 (Address) Grangeville Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nezperce	Nov. 18 1920
20. UNDERTAKER	ADDRESS
A. Mangas	Grangeville

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 46
Primary Registration District No. 2173
File No. 32246
Registered No. 15

1. PLACE OF DEATH.
County of Kootenai
City of Near Hrley
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Frances Cleek

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 27 (Day) 1860 (Year)

7. AGE: 60 Yrs. 4 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Clakmus Co. Oregon

10. NAME OF FATHER: Joseph Quinn

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Polly Walker

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) C D Cleek
(Address) 1824 N. Carlisle Spokane

15. Filed Dec 5 1920 H G Jaquet Local Registrar

SVMS - YORK CO., PTRS. & BDRS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 11:10 P.M.

The CAUSE OF DEATH* was as follows:
Acute Heart failure
Valvular

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) R. B. Mooney M. D.
19..... (Address) acting Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane, Wn — DATE OF BURIAL: Dec 7 1920

20. UNDERTAKER: Hazen and Jaquet — ADDRESS: Spokane

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 46

Primary Registration District No. 2123

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32247

Registered No. 14

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Worley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Fulton Huff

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. May (Month) 16th (Day) 1859 (Year)

7. AGE: 60 Yrs. 6 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Truck farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: Jacob Huff

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Lucinda Bond

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James D. Huff

(Address) Worley, Idaho

15. Filed Dec 3 1920

L. L. Jaeger
Local Registrar

STMS - YORK CO., PTRS. & SONS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 28 1920, to Nov 29 1920, that I last saw him alive on Nov 29 1920, and that death occured on the date stated above, at 1200 M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. F. Smith M. D.

11/29 1920 (Address) Plummer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Worley — DATE OF BURIAL: Nov. 30 1920

20. UNDERTAKER: L. L. Jaeger — ADDRESS: Plummer

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

32248

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
(No. .....) ..... St.)

File No. 3
Registered No. 22

1. PLACE OF DEATH.
County of Kootenai
City of Harrison

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret J. Eva.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
Dec 4 1877
(Month) (Day) (Year)

7. AGE
43 Yrs. 11 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Conn. U. S.

10. NAME OF FATHER: Mat Treglown.

11. BIRTHPLACE OF FATHER
(State or Country) Channel Islands Eng.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER
(State or Country) Eng.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Moses Eva
(Address) Kellogg Idaho

15.
Filed Nov 22 1920
Jno Finney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1920, to Nov 22 1920, that I last saw h[illegible] alive on Nov 21 1920, and that death occured on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:
Melancholia - Cut on brain.
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Jno Finney M. D.
Nov 22 1920 (Address) Harrison Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191..

20. UNDERTAKER: M. C. Thornhill | ADDRESS Kellogg Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

32249

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2207
(No. ....., ... St.)
File No. 3
Registered No. 70

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Kootenai
City of Harrison
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Richard Okelund

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. ..... 1 ..... (Month) (Day) (Year)

7. AGE: 43 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: .....
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) .....

15. Filed Nov 4 1920 Jos Flannery Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h... alive on Nov 2 1920 and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Fell from Bridge
fracturing Skull
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Jos Flannery M. D.
11-4 1920 (Address) Harrison

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Evansville Minn. DATE OF BURIAL ..... 191...

20. UNDERTAKER: E Cassedy ADDRESS Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

HYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 12251

Registered No. 837

1. PLACE OF DEATH

County of Kootenai

City of Coeur d'Alene (No. 908 Bancroft St.)

Registration District No. 30

Primary Registration District No. 1051

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hagen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 18 (Day) 1888 (Year)

7. AGE: 32 Yrs. 6 Mos. 29 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Martin Guttormsen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Ingrie I——

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address) Chas Hagen

15. Filed Dec 4, 1920 D D Drennan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: ~~Oct 15~~ Nov. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Nov 17 1920, that I last saw h[er] alive on Nov 16 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J O Bryn M. D.

Nov 18 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest-Cem. CdA | DATE OF BURIAL: 11-18 1920

20. UNDERTAKER: McCassedy | ADDRESS: CdAlene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 22253
Registered No. 862

1. PLACE OF DEATH
County of Kootenai
City of Coeur d Alene (No. 515 Garden St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Towne

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 20 (Day) 1855 (Year)

7. AGE: 65 Yrs. 6 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Transfer Business
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: [illegible]

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Towne
(Address) Coeur d Alene Ida

15. Filed Dec 4 1920 D D Brennan, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to Nov. 4 1920, that I last saw h.im alive on Oct 30 1920, and that death occurred on the date stated above, at 5P M.
The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) Not known mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J O Brown M. D.
Nov 6 1920 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 16 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: Nov 7 1920
20. UNDERTAKER: R B Mooney
ADDRESS: Coeur d Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 32254
Registered No. 863

1. PLACE OF DEATH
County of Kootenai
City of
(No. Dalton Gardens St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Sumner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 2 (Day) 1890 (Year)

7. AGE: 30 Yrs. 2 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home Duties
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Fred Hayes

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Almira Miller

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E Sumner
(Address) Dalton Gardens Ida

15. Filed Dec 4 1920 D D Dressman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/29 1920, to 11/2 1920, that I last saw h.. alive on 11/2 1920, and that death occurred on the date stated above, at 8:30 P.M.

The CAUSE OF DEATH* was as follows:
Pseudodiphtheria

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. D. Thurston M. D.
11/3 1920 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 1 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery | DATE OF BURIAL: Nov 3 1920

20. UNDERTAKER: L D Toomey | ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 32855
Registered No. 833

1. PLACE OF DEATH

County of Kootenai
City of Coeur D'Alene
(No. Ranch 7 miles north of City)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME HILDA AGNES CASEY

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 21 (Day) 1900 (Year)

7. AGE: 20 Yrs. 4 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: James Casey

11. BIRTHPLACE OF FATHER (State or Country): Wis,

12. MAIDEN NAME OF MOTHER: Mary Crocket

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emma Posey
(Address) Coeur d'Alene R.F.D.

15. Filed Dec 4, 19 .. D D Drennan
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 15 1920, to Nov. 30 1920, that I last saw her alive on Nov. 27 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral Thrombosis and
Cerebral Softening.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Elwood M. D.
Dec. 1920 (Address) Coeur d'Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State 20 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery | DATE OF BURIAL: 12-4 1920

20. UNDERTAKER: P B Mooney | ADDRESS: Coeur d'Alene Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32256
Registered No. 856

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene, (No. 807, 2nd St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lenora Bernhard
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 22 (Day) 1875 (Year)

7. AGE: 43 Yrs. 5 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Cooley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. Bernhard
(Address) Coeur d'Alene Ida.

15. Filed Dec 4 1920 D. W. Brenna
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 21 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 1918, to Nov. 21 1920
that I last saw h[illegible] alive on Nov 20 1920
and that death occurred on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. Dwyer M. D.
Nov. 22 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. C'D'Alene — DATE OF BURIAL: 11-23 1920

20. UNDERTAKER: McCarrecky — ADDRESS: C'D'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Kootenai

City of ..... (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30

Primary Registration District No. 1057

File No. 6257

Registered No. 837

2. FULL NAME Marion N. Von Schrilz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
fem.	wh.	single

6. DATE OF BIRTH Nov. 16. 1920
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Floyd L. Von Schrilz

11. BIRTHPLACE OF FATHER (State or Country) Wash.

12. MAIDEN NAME OF MOTHER Mary E. Pankey

13. BIRTHPLACE OF MOTHER (State or Country) Wash.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Floyd L. Von Schrilz
(Address) Bayview, Idaho.

15. Filed Dec 4 1920 D D Kreuna
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 20th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16 1920 to Nov. 19 1920
that I last saw h.. alive on Nov. 19 1920
and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:
Jaundice of the newborn

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank Wm ..... M. D.
11/20 1920 (Address) Rathdrum Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Athol Idaho — DATE OF BURIAL: Nov 21 1920

20. UNDERTAKER: O. W. Glaum — ADDRESS: Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 30
Primary Registration District No. 1051
File No. 32258
Registered No. 858

County of .....
City of .....
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy. House

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	W	Widow

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1854 (Year)

7. AGE: 66 Yrs. 1 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House-wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: Elwin N. House

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: — Bunyan

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John N. House.
(Address) Malden Wash

15. Filed Dec 4 1920 D D Drenna Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 6. 1920, to Nov. 17 1920, that I last saw h.s alive on Nov. 17 1920, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
coming Paralysis

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) Athroma

(Duration) 3 yrs. ..... mos. ..... ds.

(Signed) Ira E. Wing M. D.

11/17 1920 (Address) Rathdrum, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Idaho | DATE OF BURIAL: Nov 19 1920

20. UNDERTAKER: A. W. Stevens | ADDRESS: Rathdrum Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 32260
Registered No. 1240

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... , ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Griffith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Oct (Month) 27 (Day) 1870 (Year)

7. AGE: 50 Yrs. ..... Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Contractor
(b) General nature of industry, business or establishment in which employed (or employer): Road Work

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Irwin Griffith

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Rhoda Gregg.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. M. Griffith
(Address) Moscow

15. Filed 11/27 1920 W H Carothers Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1920, to Nov 25 1920, that I last saw him alive on Nov 25 1920, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Gangrene of abdominal wall and gas-
tric ulcer of stomach

(Duration) ..... Yrs. ..... mos. 9 ds.
Contributory (Secondary) Perforation of gastric ulcer (Duration) ..... yrs. ..... mos. 5 ds.

(Signed) F. W. Leitch M. D.
11/27 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pullman — DATE OF BURIAL: Nov 29 1920

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Moscow

Registration District No. 61
Primary Registration District No. 1011
(No. Carithers Hospital St.)

File No. 32261
Registered No. 133

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jean Lois Oberg

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: November 8 (Month) (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 8 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *min?*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER John Oberg.

11. BIRTHPLACE OF FATHER (State or Country) Sweden.

12. MAIDEN NAME OF MOTHER Hattie Erickson

13. BIRTHPLACE OF MOTHER (State or Country) Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs John Oberg
(Address) Moscow Ida

15.
Filed Nov 16 1920 W. H. Carithers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 16 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1920 to Nov 16 1920
that I last saw her alive on Nov 16 1920
and that death occurred on the date stated above, at 8:40 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth. (6½ mos.)

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Carithers M. D.
Nov 16" 1920 (Address) Moscow, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Ida
DATE OF BURIAL: Nov 17 1920

20. UNDERTAKER: Glen Price
ADDRESS: Moscow

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 101
Primary Registration District No. 1011
File No. 32202
Registered No. 138

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Minear

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 11 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 13 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Latah Co. Idaho

10. NAME OF FATHER Virgil Luther Minear

11. BIRTHPLACE OF FATHER (State or Country) Louisville Missouri

12. MAIDEN NAME OF MOTHER Verna M. Howard

13. BIRTHPLACE OF MOTHER (State or Country) Rockland Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Minear
(Address) 404 College Ave

15.
Filed Nov. 16 1920 W. H. Carruthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11 1920, to Nov 11 1920, that I last saw h. im alive on Nov 11 1920, and that death occurred on the date stated above, at 6:10 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Virgil M. Gilchrist M. D.

Nov. 12 1920 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow Ida — DATE OF BURIAL: Nov 12 1920

20. UNDERTAKER: Glen Grice — ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32263

Registered No. 137

1. PLACE OF DEATH

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William H. Beardsley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 8th (Day) 1870 (Year)

7. AGE: 50 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Common Laborer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: George W. Beardsley

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Nancy L. Flack

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. D. Reddall

(Address) 1636 - 7th St. Seattle Wash

15. Filed 11/13 1920 W. H. Walters Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Found Dead in Bed
Supposed Heart Trouble
(No Inquest Held)

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Glen Price M.D. Coroner

11/13 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 11/14 1920

20. UNDERTAKER: Glen Price | ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32264

Registered No. 136

1. PLACE OF DEATH

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecka Jane Johnston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: April (Month) 2 (Day) 1834 (Year)

7. AGE: 66 Yrs. 7 Mos. ..... ds. 7

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Thomas Bradfield

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Johnston

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. M. Johnston

(Address) Moscow

15. Filed 11/10 1920 W H Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1920, to Nov 9th 1920, that I last saw h[er] alive on Nov 9th 1920, and that death occurred on the date stated above, at 9:15 P.M.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

..... (Duration) Several months

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Leitch M. D.

11/10 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 11/14 1920

20. UNDERTAKER: Glen Price — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Latah
City of Viola R.F.D.

Registration District No. 61
Primary Registration District No. 2141
(No. ....., ... St.)

File No. 32265
Registered No. 135

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alta Mc Coy

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 26 1905
(Month) (Day) (Year)

7. AGE: 15 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Latah Co Idaho.

10. NAME OF FATHER: O. B. McCoy.

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Mary O'Dell Bausch

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. B. McCoy
(Address) Viola, Wash.

15.
Filed Nov 16 1920 R. H. Carothers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1920, to Oct 8 1920
that I last saw h[illegible] alive on Oct 7 1920
and that death occurred on the date stated above, at 7 a M.

The CAUSE OF DEATH* was as follows:
Tuberculosis (Pulmonary)

— (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Virgil M. Gilchrist M. D.
Oct. 8 1920 (Address) Moscow, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Viola
DATE OF BURIAL: Oct. 9 1920

20. UNDERTAKER: Glen Price
ADDRESS: Moscow Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
(No. ..... St.)

File No. 32266
Registered No. 134

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cynthia D. Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb (Month) 22 (Day) 1858 (Year)

7. AGE: 62 Yrs. 9 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Texas

10. NAME OF FATHER: James Travis

11. BIRTHPLACE OF FATHER (State or Country): Texas.

12. MAIDEN NAME OF MOTHER: Martha Allen

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. C. Smith
(Address) Moscow

15. Filed 11/9 1920 W. St. Loar Withers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 20 — 1920, to Nov. 8 — 1920, that I last saw h. alive on Nov. 8 — 1920, and that death occurred on the date stated above, at 4 40 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) 2 yrs. 0 mos. — ds.

(Signed) J. C. Price M. D.

11/9 1920 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 11/10 1920

20. UNDERTAKER: Glen Rice
ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 32267
Registered No. 133

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 11 (Day) 1890 (Year)

7. AGE: 30 Yrs. 7 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: Alfred Schedin

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Augusta Schoustrom

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas Nelson
(Address) Moscow

15. Filed 11/7 1920 W. H. Saunders Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 23 1920, to Nov 6 1920, that I last saw h[er] alive on Nov 6 1920, and that death occurred on the date stated above, at 0.30 A.M.

The CAUSE OF DEATH* was as follows:
Tubercular Meningitis
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Leitch M. D.
11/7 1920 (Address) Moscow

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 11/9 1920

20. UNDERTAKER: Allen Grice — ADDRESS: Moscow

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 32268
Registered No. 132

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William F Wakefield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 14 (Day) 1854 (Year)

7. AGE: 66 Yrs. 9 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Elijah Wakefield

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Nancy Smith

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl Wakefield
(Address) Cheney Wash

15. Filed 11/7 1920 W. H. Carruthers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1920, to Nov 6th 1920, that I last saw him alive on Nov 6th 1920, and that death occurred on the date stated above, at 4:30 P. M.

The CAUSE OF DEATH* was as follows: Carcinoma of the liver
Had been complaining for several months
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Leitch M. D.
11/7 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 14 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Moscow Idaho

19. PLACE OF BURIAL OR REMOVAL: Moscow
DATE OF BURIAL: 11/8 1920

20. UNDERTAKER: Glen Grice
ADDRESS: Moscow

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32269
Registered No. 131

1. **PLACE OF DEATH**

County of Latah

City of Moscow

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 91

Primary Registration District No. 1021

(No. ..... St.)

2. **FULL NAME** Elvie Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Female

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Single

6. **DATE OF BIRTH**: October (Month) 24 (Day) 1920 (Year)

7. **AGE**: Yrs. ..... Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country): Moscow Idaho

10. **NAME OF FATHER**: Ray A. Williams

11. **BIRTHPLACE OF FATHER** (State or Country): Springfield S. Dakota

12. **MAIDEN NAME OF MOTHER**: Minnie Stilwell

13. **BIRTHPLACE OF MOTHER** (State or Country): New York City N.Y.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Ray A. Williams

(Address) Moscow Idaho

15. Filed 11/6 1920 M. T. Gardners
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: November (Month) 6 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** October 24 1920, to Nov. 6 1920 **that I last saw h.er alive on** Nov. 5 1920, **and that death occurred on the date stated above, at** 7A M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus
Spina Bifida

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Virgil M. Gilchrist M. D.

Nov. 6 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Moscow — **DATE OF BURIAL**: 11/8 1920

20. **UNDERTAKER**: Glen Price — **ADDRESS**: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Latah — Registration District No. 62

City of Genesee — Primary Registration District No. 2142 — (No. ....., ... St.)

File No. 32270

Registered No. 5

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Don't Know (Month) (Day) 1 (Year)

7. AGE: about 50 yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labor
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. L. Brackett
(Address) Genesee, Ida.

15. Filed Oct. 10th 1920 W. H. Cheney Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-5 1920 to 10-9 1920
that I last saw h..... alive on 1920,
and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:
Fractured Skull
Kicked by Horse

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. H. Cheney M. D.
10-9 1920 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Genesee Idaho — DATE OF BURIAL: 10-10 1920

20. UNDERTAKER: F E Lambert — ADDRESS: Genesee

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32271
Registered No. 6

1. PLACE OF DEATH.
County of Latah
City of Genesee
(No. ..... St.)
Registration District No. 6
Primary Registration District No. 4 4 2

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David Sumler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH.
Feb (Month) 24 (Day) 1877 (Year)

7. AGE
43 Yrs. 8 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Elsas Lorine Germany

10. NAME OF FATHER John G. Sumler

11. BIRTHPLACE OF FATHER
(State or Country) Germany

12. MAIDEN NAME OF MOTHER Katherine Walter

13. BIRTHPLACE OF MOTHER
(State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Susie Giesel
(Address) Juliaetta Idaho

15.
Filed 11-11- 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 7 1920, to Nov 9 1920, that I last saw h— alive on Nov. 9 1920, and that death occured on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary Edema

(Duration) Yrs. 2 mos. 5 ds.
Contributory (Secondary) Pleurisy Hepatized

(Duration 3 yrs. mos. ds.
(Signed) W. E. Thorn M. D.
11-11 1920 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fir Ridge	11-14 1920
20. UNDERTAKER J. E. Brouchoux	ADDRESS Juliaetta

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYRNE - YORK CO., PTRS. & BDRS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Latah
City of Genesee
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62
Primary Registration District No. 2142
(No. ..... St.)

File No. 32272
Registered No. 7
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Catherine Heinrich

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	W	Widow

6. DATE OF BIRTH: Dec. (Month) 19 (Day) 1839 (Year)

7. AGE: 81 yrs. 1 mos. 27 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Peter Gude

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: [illegible]

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Henry
(Address) 704 McKay Apts Seattle Wash

15.
Filed Nov. 17 1920 L. O. Ellen Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to Nov. 15 1920 that I last saw her alive on Nov. 15 1920 and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Edema

(Duration) yrs. mos. 3 ds.
Contributory (Secondary) Pericarditis
(Duration) 2 yrs. mos. ds.
(Signed) L. O. Ellen M. D.
11-17 1920 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee Idaho | DATE OF BURIAL: 11-18- 1920

20. UNDERTAKER: F. E. Lambert | ADDRESS: Genesee Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Fulah
City of Genesee
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 62
Primary Registration District No. 2142
(No. ____, ____ St.)

File No. 32273
Registered No. 8
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Minnie Schwenkhorst

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F	White	married

6. DATE OF BIRTH: Oct. (Month) 3 (Day) 1874 (Year)

7. AGE: 46 yrs. / mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Louis Olday

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Sophia Bartels

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry Flowers
(Address) Genesee Idaho

15. Filed 11-29- 1920 W N Ehrem Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 28th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 16 1920 to Nov 28 1920, that I last saw her alive on Nov 28- 1920 and that death occurred on the date stated above, at 11 A. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ... yrs. 1 mos. 4 ds.

Contributory (Secondary) Syphilis Fever

(Duration) ... yrs. ... mos. 25 ds.

(Signed) W N Ehrem M. D.

11-29 1920 (Address) Genesee

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Genesee Idaho | DATE OF BURIAL: 11-30 1920

20. UNDERTAKER: J. E. Lambert | ADDRESS: Genesee

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
File No. 32274
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Potlatch
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Edward Lynd.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct (Month) 30 (Day) 1920 (Year)

7. AGE ....Yrs. ....Mos. 10 ds.
IF LESS than 1 day how many ....hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Baby.
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ida Latah Co.

10. NAME OF FATHER R. E. Lynd.

11. BIRTHPLACE OF FATHER (State or Country) Washington

12. MAIDEN NAME OF MOTHER West.

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) R. E. Lynd.
(Address) Palouse. Wash.

15. Filed Nov 10 1920 J. M. Thompson Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 30 1920, to Nov 9 1920, that I last saw h.... alive on Nov 8 1920, and that death occured on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Inanition

.....(Duration) ....Yrs. ....mos. 9 ds.

Contributory (Secondary) .....

.....(Duration ....yrs. ....mos. ....ds.

11/9 (Signed) E. K. Hoff M. D.
1920 (Address) Palouse. Wash.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Palouse — DATE OF BURIAL Nov 9 1920

20. UNDERTAKER E. M. Irwin. — ADDRESS Palouse.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 65
Primary Registration District No. 2145
(No. .... St.)

File No. 32275
Registered No. .....

1. PLACE OF DEATH.
County of Latah
City of Potlatch
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rudolph George Schmidt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Dec (Month) 25 (Day) 1906 (Year)

7. AGE
13 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... School boy
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) S. D.

10. NAME OF FATHER W. J. Schmidt

11. BIRTHPLACE OF FATHER (State or Country) Illinois

12. MAIDEN NAME OF MOTHER Kobierowski

13. BIRTHPLACE OF MOTHER (State or Country) Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) .....
(Address) Wm J Schmidt

15.
Filed Nov 15th 1920 Dr J.W. Thompson
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191...,
that I last saw h ✓ alive on ✓ 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Drowning by accident

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J.W. Thompson M. D.
12/11 1920 (Address) Potlatch

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Potlatch Cemetery — DATE OF BURIAL: 16/11 1920

20. UNDERTAKER: E.W. Irwin — ADDRESS: Palouse.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOKS. 24654

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD

V.S. No. 1

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PLACE OF DEATH

County of Latah

City or Town of Palouse

Registration Dist. No. 65

[If death occurs away from USUAL RESIDENCE give facts called for under "Special Information."]

WASHINGTON STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

Record No.

File No. 32276

Registered No. 2145

(No. ..... St.; ..... Ward)

[If death occurred in a Hospital or Institution give its NAME instead of street and number.]

Full Name Jennie Mae Robinson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: April 21, 1873. (Month) (Day) (Year)

7 AGE: 47 yrs. 2 mos. 7 ds. If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Oregon.

PARENTS

10 NAME OF FATHER: T Spencer.

11 BIRTHPLACE OF FATHER (State or country): Missouri

12 MAIDEN NAME OF MOTHER: Mary Cattle.

13 BIRTHPLACE OF MOTHER (State or country): Missouri

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. L. F. Robinson

(Address) Palouse, Wash.

15 Filed Nov 20 20 J. W. Thompson M.D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Nov 19, 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 6, 1920, to Nov 18, 1920, that I last saw her alive on Nov 18, 1920, and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH * was as follows:

..... Cancer of Breast

..... (Duration) 3 yrs. ..... mos. ..... ds.

Contributory (SECONDARY) None

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. K. Wolfe, M. D.

Nov 20, 1920 (Address) Palouse, Wn.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death ..... yrs. ..... mos ..... ds. In the State ..... yrs. ..... mos. ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Palouse — DATE OF BURIAL: Nov 21, 1920

20 UNDERTAKER: E. W. Drusin — ADDRESS: Palouse

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 68

Primary Registration District No. ____

File No. 32277

Registered No. ____

1. PLACE OF DEATH.

County of Latah

City of Juliaetta (No. ____, ____ St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hardin Trenary

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. ×: May 7 (Month) (Day) 1853 (Year)

7. AGE: 19 20 / 18 53 / 1 4 — Yrs. ____ Mos. ____ ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)... Retired

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER ×: Benjmen Trenary

11. BIRTHPLACE OF FATHER ×: (State or Country) none

12. MAIDEN NAME OF MOTHER ×: ____

13. BIRTHPLACE OF MOTHER ×: (State or Country) none

14. THE ABOVE IS TRUE, TO THE BEST OF MY KNOWLEDGE.
(Informant) × Mary Trenary
(Address) Juliaetta Idaho

15. Filed 10 25 1920 — R. T. Pepple, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 1918, to Oct 1st 1920, that I last saw him alive on Oct 1st 1920, and that death occured on the date stated above, at 4:20 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(Duration) 2 Yrs. 0 mos. 0 ds.

Contributory (Secondary) ____

(Duration ____ yrs. ____ mos. ____ ds.

(Signed) W. R. Rothwell M. D.

Oct 25 1920 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? ____

Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Cem — DATE OF BURIAL: 10-25 1920

20. UNDERTAKER: E. E. Groves — ADDRESS: Juliaetta

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 68

Primary Registration District No.

File No. 32278

Registered No.

1. PLACE OF DEATH.

County of Latah

City of Juliaetta

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Hampton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Oct (Month) 24 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Infant
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Joseph D Hampton

11. BIRTHPLACE OF FATHER (State or Country): Arkansas

12. MAIDEN NAME OF MOTHER: Mamie Hom

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J D Hampton
(Address) Juliaetta Idaho

15. Filed Oct 29 1920 R F Pettit Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h... alive on ..... 191...,
and that death occured on the date stated above, at 3 P M.
The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Home Lot.	10-29 1920
20. UNDERTAKER	ADDRESS
None	

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32279
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 41
Primary Registration District No. 2116
(No. ....., ... St.)

2. FULL NAME Jennie Marshall Van Skiver

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Feb. (Month) 3rd. (Day) 1840. (Year)

7. AGE: 80 Yrs. 9 Mos. 23 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Margaretville N.S.

10. NAME OF FATHER Given name Not known Marshall

11. BIRTHPLACE OF FATHER
(State or Country) Not known

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Homer Harris
(Address) Salmon Idaho

15.
Filed 12-10 1920. M. D. Greene Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 27 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 24 1920 to Nov. 27 1920, that I last saw h[illegible] alive on Nov. 28 1920, and that death occurred on the date stated above, at 1.00 a M.

The CAUSE OF DEATH* was as follows:
Lobar pneumonia
.....
.....
.....(Duration) ..... Yrs. 1 mos. 4 ds.
Contributory (Secondary) Myocarditis
.....(Duration) ..... Yrs. 7 mos. ..... ds.
(Signed) C. D. Stratton M. D.
11/29 1920 (Address) Salmon, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 11-29- 1920

20. UNDERTAKER: W. C. Dobbs — ADDRESS: Salmon Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH 32280

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 8
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 42
Primary Registration District No. 2153
(No. ....., ... St.)

1. PLACE OF DEATH
County of Lemhi
City of Leadore
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ella Ray Fayle

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. October (Month) 20 (Day) 1880 (Year)

7. AGE: 40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: B D Thomas

11. BIRTHPLACE OF FATHER (State or Country): not known

12. MAIDEN NAME OF MOTHER: Matilda Thomas

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. R. Fayle
(Address) Idaho Leadore

15. Filed 11/6/ 1920. H B Keller Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 24th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 21st 1920 to Oct 24th 1920 that I last saw h[er] alive on Oct 24th 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:
"Grippe" which later resulted in Rheumatism that affected heart & caused death
(Duration) ..... Yrs. ..... mos. 5 ..... ds.
Contributory (Secondary) Grippe Rheumatism
(Duration) ..... Yrs. ..... mos. 4 ..... ds.
(Signed) Irvin B. Keller M. D.
10/25 1920. (Address) Leadore, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho — DATE OF BURIAL ..... 191...

20. UNDERTAKER: W. C. Jacobs — ADDRESS: Salmon Idaho

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32281
Registered No. 60

1. PLACE OF DEATH.
County of Lewis
City of Nezperce
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 47
Primary Registration District No.
(No. , St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Elbert William Barber

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	

6. DATE OF BIRTH: May 10 1920 (Month) (Day) (Year)

7. AGE: ..yrs. ..mos. ..ds. IF LESS than 1 day how many 9 hrs. or ..min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nezperce

10. NAME OF FATHER: Joe R. Barber

11. BIRTHPLACE OF FATHER (State or Country): Portland Ore.

12. MAIDEN NAME OF MOTHER: Maud L. Mitchell

13. BIRTHPLACE OF MOTHER (State or Country): Arlington Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe R Barber
(Address)

15. Filed 11 – 18 1920 Albert Huff Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 10 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1920, to Nov 10 1920 that I last saw h.. alive on Nov 10 1920 and that death occurred on the date stated above, at a M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) ..yrs. ..mos. 1 ds.
Contributory (Secondary) Injection Ammunition
(Duration) ..yrs. ..mos. ..ds.

(Signed) ..... M. D.
..19.. (Address) Nezperce Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..yrs. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nezperce Cemetery — DATE OF BURIAL: Nov 10 1920

20. UNDERTAKER: Albert Huff — ADDRESS: Nezperce Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2177
(No. ..... St.)

File No. 32282
Registered No. 87

1. PLACE OF DEATH.
County of Madison
City of Rexburg

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence Randall

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov. (Month) 6 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg, Idaho

10. NAME OF FATHER: Joseph L. Randall

11. BIRTHPLACE OF FATHER (State or Country): Lyman, Idaho

12. MAIDEN NAME OF MOTHER: Vera Lake

13. BIRTHPLACE OF MOTHER (State or Country): Preston, Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Ray Randall
(Address) Rexburg

15. Filed Nov 26 1920
Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24854

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1920, to Nov 25 1920, that I last saw him alive on Nov 25 1920 and that death occured on the date stated above, at 11. a. M.

The CAUSE OF DEATH* was as follows:
Bronchitis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Nelson M. D.
11-26 1920 (Address) Rexburg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lyman, Idaho — DATE OF BURIAL: Nov. 27 1920

20. UNDERTAKER: John M. Richards — ADDRESS: Rexburg, Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2179
File No. 32285
Registered No. 82

1. PLACE OF DEATH
County of Madison
City of Rexburg
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Warren Barney

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	white	Married

6. DATE OF BIRTH: Apr # (Month) 11 (Day) 1881 (Year)

7. AGE: 39 Yrs. 6 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Utah Idaho Sugar Co.

9. BIRTHPLACE (State or Country): Colorado

10. NAME OF FATHER: Walter Barney

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Ann Allred

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Ann Allred Barney
(Address) Sugar City Ida

15. Filed Nov 10 1920 G G Espe Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 8 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 8th 1920 to November 8 1920
that I last saw h. alive on November 8th 1920
and that death occurred on the date stated above, at 4:20 P.M.
The CAUSE OF DEATH* was as follows:

Accident - Crushing blow to chest and back about 6 hours
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. B. Evans M. D.
11-11 1920 (Address) Sugar City,

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Welford, Ida — DATE OF BURIAL: Nov 11 1920

20. UNDERTAKER: Rexburg Furniture Co. — ADDRESS: Rexburg Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison

City of Sugar City

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10

Primary Registration District No. 2178

(No. ..... St.)

File No. 36284

Registered No. 83

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Theodocia Fannie Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH

March 8th 1851
(Month) (Day) (Year)

7. AGE

69 Yrs. 8 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Utah

10. NAME OF FATHER William H. Walker

11. BIRTHPLACE OF FATHER
(State or Country) Vermont

12. MAIDEN NAME OF MOTHER Mary J. Van Velzer

13. BIRTHPLACE OF MOTHER
(State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank L. Davis

(Address) Sugar City

15. Filed Nov 15 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

November 12th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 11 1920 to November 12 1920 that I last saw h.. alive on November 12th 1920 and that death occurred on the date stated above, at 0.20 P. M.

The CAUSE OF DEATH* was as follows:

Uraemic Poisoning

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. D. Evans M. D.

11-17 1920 (Address) Sugar City, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Salt Lake City, Utah.	Nov. 16th 1920
20. UNDERTAKER David Young	ADDRESS Rexburg, Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

32285

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 100
Primary Registration District No. 2178
File No. ....
Registered No. 84

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hannah Blackburn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem-
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 23 (Day) 1874 (Year)

7. AGE: 46 Yrs. ..... Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Charles Burns

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Martha (Unknown)

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno Blackburn
(Address) Rexburg

15. Filed 11/18 1920 G H Estes Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191.....
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ....., ...M.
The CAUSE OF DEATH* was as follows:
Paralysis of bowel
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) G H Estes M. D.
.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: DATE OF BURIAL 11/18 1920

20. UNDERTAKER: J Rogers ADDRESS Rexburg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32286

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 10

Primary Registration District No. 2178

County of Madison

City of Rexburg (No. ....., ... St.)

File No. .....

Registered No. 85

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marcelle Evans

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: November (Month) 13th (Day) 1920 (Year)

7. AGE: --- Yrs. --- Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jesse P. Evans

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Sylvia M. Parker

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse P Evans
(Address) Rexburg Ida.

15. Filed Nov 16 1920 G G Koepe Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-13 1920, to 11-16 1920, that I last saw h[illegible] alive on 11-13 1920, and that death occurred on the date stated above, at 10 P M.

The CAUSE OF DEATH* was as follows:

Malena

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. 1 ds.

(Signed) J. S. Mercer M. D.

19..... (Address) Rexburg, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City — DATE OF BURIAL: Nov. 17th '20

20. UNDERTAKER: David Young — ADDRESS: Rexburg, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 02481
Registered No. 86.

1. PLACE OF DEATH

County of Madison

City of Rexburg.

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10

Primary Registration District No. 2178

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Etta Berrett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August 8th (Month) 1917 (Year)

7. AGE: 3 Yrs. 3 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Lewis Berrett

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Myrtle Montague

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Myrtle Berrett

(Address) Rexburg, Idaho.

15. Filed Nov. 17 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920, to Nov 16 - 1920 that I last saw her alive on Nov 16 - 1920, and that death occurred on the date stated above, at 740 P M.

The CAUSE OF DEATH* was as follows:

Scarlet fevers.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lorin L Rich M. D.

11/17 1920 (Address) Rexburg Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Annis, Ida.

DATE OF BURIAL: Nov. 18 1920

20. UNDERTAKER: John Phillips

ADDRESS: Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison

City of Rexburg.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ..... St.)

File No. 6688

Registered No. 87

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William M. Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: June 22 (Month) (Day) 1901 (Year)

7. AGE: 19 Yrs. -- Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Thomas F. Smith

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Catherene McCarrey

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thomas F. Smith

(Address) Sugar City

15. Filed Nov 22 1920

G. L. Espe
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 21st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 21 1920 to November 21 1920 that I last saw h. am alive on November 21 1920 and that death occurred on the date stated above, at 4.13 P.M.

The CAUSE OF DEATH* was as follows:

Accidentally burned at Sugar Factory. about 4 hours.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) V. B. Evans M. D.

11/23 1920 (Address) Sugar City, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sugar City, Idaho

DATE OF BURIAL: Nov. 25 1920

20. UNDERTAKER: John Phillips

ADDRESS: Rexburg, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Madison.

City of Sugar City.

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 100

Primary Registration District No. 2178

(No. ....., ... St.)

File No. 32289

Registered No. 88

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Miller.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: November (Month) 21 (Day) 1920 (Year)

7. AGE: ..... Yrs. ----- Mos. ----- ds.

IF LESS than 1 day how many ----- hrs. or 30 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sugar City, Idaho

10. NAME OF FATHER: George Miller

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Louise Kidd

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George Miller

(Address) Sugar City Ida.

15. Filed Nov 23 1920

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 21 1920, to ..... 19.....

that I last saw him alive on November 21 1920

and that death occurred on the date stated above, at 9a. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G. B. Green M. D.

11/23 1920 (Address) Sugar City, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sugar City

DATE OF BURIAL: Nov. 21 1920

20. UNDERTAKER: David Young

ADDRESS: Rexburg, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

32291

Killen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 51
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Minidoka
City of Heyburn
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2015
(No. ....., ... St.)

2. FULL NAME Edward Miller

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.
6. DATE OF BIRTH: March (Month) 12 (Day) 1892 (Year)
7. AGE: 28 Yrs. 6 Mos. 23 ds. IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho.
10. NAME OF FATHER: Ed. Miller
11. BIRTHPLACE OF FATHER (State or Country): Unknown
12. MAIDEN NAME OF MOTHER: Hattie Smith.
13. BIRTHPLACE OF MOTHER (State or Country): Nevada.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. D. Miller
(Address) Boise Idaho, Route 2.
15. Filed Nov. 20 1920 E. E. Elmore Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 5 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct. 1 1920 to Oct 5 1920
that I last saw him alive on Oct 5 1920
and that death occurred on the date stated above, at 9:15 P. M.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
.....(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Meningitis
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) V. P. Killen M. D.
.....19.... (Address) Rupert Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Heyburn Ida. DATE OF BURIAL: 10/6/1920
20. UNDERTAKER: L. B. Galloway ADDRESS: Burley Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32292

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19

Primary Registration District No. 2015

File No.

Registered No. 98

1. PLACE OF DEATH

County of Minidoka

City of Rupert

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elva C. Cone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1909 (Year)

7. AGE: 10 Yrs. 9 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nevada

10. NAME OF FATHER: Jessie Cone

11. BIRTHPLACE OF FATHER (State or Country): Arizona

12. MAIDEN NAME OF MOTHER: Ellen Schmidtdt

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Annie Dutson

(Address) Rupert Idaho

15. Filed Nov 20 1920 E. O. Ehmer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9 1920, to Oct 14 1920, that I last saw h-- alive on Oct 15 1920 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows: Acute Tonsilitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

10-15 1920 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elg Nevada — DATE OF BURIAL: Oct 15 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

32293

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 3015
File No.
Registered No. 59

1. PLACE OF DEATH
County of Minidoka
City of Rexburg
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Buffington
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: W (Write one word.)

6. DATE OF BIRTH: Mar (Month) 13 (Day) 1833 (Year)

7. AGE: 87 Yrs. 7 Mos. 13 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Richard Amos

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lydia Pannen
(Address) Rexburg

15. Filed Dec 3 1920
E. E. Chase
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Found dead in bed

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Goodman Coroner M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery
DATE OF BURIAL: Oct 29 1920

20. UNDERTAKER: W. A. Goodman
ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 32294
Registered No. 65

1. PLACE OF DEATH
County of Minidoka
City of Rupert Ida
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adam C. Masoner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 6 (Day) 184[illegible] (Year)

7. AGE: 73 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Hiram Masoner

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Margaret Mc Coy

13. BIRTHPLACE OF MOTHER (State or Country): Tenn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas E Masoner
(Address) Rupert Ida

15. Filed Dec. 3 1920
E A Ehmore
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 11 1920, to July 2 1920
that I last saw [illegible] alive on July 1 1920
and that death occurred on the date stated above, at 11 a.m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach

(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E A Ehmore M. D.
12-2-1920 (Address) Rupert. Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cem
DATE OF BURIAL: 7-4 1920

20. UNDERTAKER: W A Goodman
ADDRESS: Rupert Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 32295
Registered No. 61

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Benjamin C Winter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Apr (Month) 2 (Day) 1917 (Year)

7. AGE: 5 Yrs. 8 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Ben Winters

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Anna Ament

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ben Winters
(Address) Rupert Idaho

15. Filed Dec 3 1920
E. O. Ehmke
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1920 to Nov 7 1920
that I last saw h.. alive on Nov 7 1920
and that death occurred on the date stated above, at 10a M.
The CAUSE OF DEATH* was as follows: Scarlet Fever

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) 2 wks. ..... mos. ..... ds.
(Signed) [illegible] M. D.
12-3-1920 (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Nov 7 1920

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Minidoka

City of Rupert (No. ....., ... St.)

Registration District No. 19

Primary Registration District No. 2015

File No. 32290

Registered No. 62

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Floyd Williams

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Child

6. DATE OF BIRTH: June 23 (Month) (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Neal Williams

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Hazel Clevenger

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Dec. 3 1920 E. O. Ehmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 28 1920, to Sept. 2 1920, that I last saw him alive on Sept 2 1920, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:
Whooping Cough
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. O. Ehmore M. D.
19..... (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Dec 19 20
20. UNDERTAKER	**ADDRESS**
W. G. Gardner	Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Census

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 205
File No. 22207
Registered No. 63

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Twila Jolley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Child

6. DATE OF BIRTH: Jan (Month) 11 (Day) 1920 (Year)

7. AGE: Yrs. 8 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Magnus Jolley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Theda Moneu

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theda Jolley
(Address) Rupert

15. Filed Dec. 3 1925 E. H. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Pertussis
(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) E. H. Elmore M. D.
19..... (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Cemetery
DATE OF BURIAL: Sept 22 19 25

20. UNDERTAKER: W. G. Gardner
ADDRESS: Rupert

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32298

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No.
Registered No. 65

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edgar Reynold Peterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (Write the word.)

6. DATE OF BIRTH: Jan. (Month) 9 (Day) 1918 (Year)

7. AGE: 2 Yrs. 10 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John August Peterson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Anna England

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John August Peterson
(Address) Rupert Idaho.

15. Filed Dec. 3 1925 E. B. Elmore Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 29 1920, to Dec 1 1920, that I last saw him alive on Dec 1 1920, and that death occurred on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. B. Elmore M. D.

19 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jackson Cemetery — DATE OF BURIAL: Dec 1 1920

20. UNDERTAKER: W. C. Gardner — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of **Edgar Reynold Peterson**,

now lying buried in **Jackson Cemetery** Cemetery, in the City or Town of **Near Rupert**

County of **Minidoka** State of Idaho, who died on the **1** day of **December**, 1**920**, Aged **2** years **10** months

22 days, the cause of death being **Appendicitis** and not directly or indirectly by diphtheria;(membranous croup);scarlet fever;smallpox;leprosy;asiatic cholera;typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

Dr. E. H. Elmore attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by **private** private or railway conveyance

to **Riverside** Cemetery in the City or Town of **Heyburn** County of **Minidoka**

State of **Idaho** to take effect upon the approval by the local board of health of the City, Town, or County of **Minidoka** it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this **27th** day of **March**, A.D. 19**62**.

Permit issued to:
Robert C. Walk
Walk Mortuary
Rupert, Idaho

W. W. Benson
by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of_____ State of Idaho, this_____ day of_____, 19__.

Health Officer

FORM BH 56-019

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 8899
Registered No. 66

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ross H. Ratliff
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 26 (Day) 1883 (Year)

7. AGE: 37 Yrs. 2 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Ephrahan R Ratliff

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Elizabeth Hendrick

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Eliza Ratliff
(Address) Rupert Idaho

15. Filed Dec 3 1920 E O Elmore, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 29 1920, to Nov 4 1920 that I last saw him alive on Nov 4 1920, and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ..... Yrs. ..... mos. 14 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J B Kemagy M. D.
12/3 1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Deeds Cemetery — DATE OF BURIAL: Nov 4 1920

20. UNDERTAKER: W. J. Goodman — ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 32300
Registered No. 67

1. PLACE OF DEATH

County of Minidoka
City of Rupert
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Klebe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 16 (Day) 1859 (Year)

7. AGE: 60 Yrs. 1 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Gerhart Sudengor

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Dont I Know

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Klebe
(Address): Rupert Idaho

15. Filed: Dec 3 1920
E. O. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8 1920, to Nov. 17 1920, that I last saw her alive on Nov. 8 1920, and that death occurred on the date stated above, at 10 A M.
The CAUSE OF DEATH* was as follows:

Tumor of brain

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) J B Kennedy M. D.
12/3 1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I O O F Cemetery — DATE OF BURIAL: Nov 19 1920

20. UNDERTAKER: W. G. Goodman — ADDRESS: Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 32301
Registered No. 68

1. PLACE OF DEATH
County of Jerome
City of Eden
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Lee Gofourth
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: August (Month) 5 (Day) 1918 (Year)

7. AGE: 2 Yrs. 3 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. H. Gofourth

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Amanda Walling

13. BIRTHPLACE OF MOTHER (State or Country): Tennessee

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Gofourth
(Address) Eden Idaho

15. Filed Dec. 3 1920 E. O. Elmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920, to Nov 29 1920, that I last saw him alive on Nov 28 1920, and that death occurred on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:
Terminal bronchial pneumonia following acute colon bacillus infection
(Duration) ..... Yrs. 1 mos. 4 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) E. L. Berry M. D.
Nov 30 1920 (Address) Hazelton, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Tennessee
DATE OF BURIAL: Dec 1 1920

20. UNDERTAKER: W. A. [illegible]
ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 19

Primary Registration District No. 2015

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33302

Registered No. 69

1. **PLACE OF DEATH**

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Earnest Ray Seaman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (write the word.) Child

6. **DATE OF BIRTH** June 5th 1919
(Month) (Day) (Year)

7. **AGE** 1 Yrs. 3 Mos. 7 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work ..... Child

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Idaho

10. **NAME OF FATHER** Geo Seaman

11. **BIRTHPLACE OF FATHER** (State or Country) Missouri

12. **MAIDEN NAME OF MOTHER** Bertha Hutton

13. **BIRTHPLACE OF MOTHER** (State or Country) Missouri

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs Bertha Seaman

(Address) Rupert Idaho

15. Filed Dec 3 1920

E. O. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Sept 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Sept 12 1920 that I last saw him alive on Sept 1 1920 and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Drowned.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

12-8 1920 (Address) Rupert.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** IOOF Cemetery — **DATE OF BURIAL** Sept 16 1920

20. **UNDERTAKER** W. G. Gudmundsen — **ADDRESS** Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Elmore

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 19
Primary Registration District No. 2015
File No. 32303
Registered No. 76

1. PLACE OF DEATH
County of Mundoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Reuben Hiatt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 28 (Day) 1857 (Year)

7. AGE: 69 Yrs. 8 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Elihu Hiatt

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William J Hiatt
(Address) Rupert Idaho

15. Filed Dec. 3 1920 E. E. Elmore
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 20 1920, to Sept. 1 1920
that I last saw him alive on Aug 16 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary) Chronic Nefritis
(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) E. E. Elmore M. D.
19..... (Address) Rupert. Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery
DATE OF BURIAL: Sept 3 1920

20. UNDERTAKER: W. C. Goodwin
ADDRESS: Rupert Ida

FORM V. S. No. 5-25 M. 1-19.

Killen

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Minidoka — Registration District No. 19

City of Rupert — Primary Registration District No. 205

(No. ..... St.)

File No. 32304

Registered No. 73

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Stillbirth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Infant

6. **DATE OF BIRTH**: Nov. (Month) 14 (Day) 1920 (Year)

7. **AGE**: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 5 hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: Still Born

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. **BIRTHPLACE** (State or Country): .....

10. **NAME OF FATHER**: C. R. Wiggins.

11. **BIRTHPLACE OF FATHER** (State or Country): Utah

12. **MAIDEN NAME OF MOTHER**: Florence Walker

13. **BIRTHPLACE OF MOTHER** (State or Country): Kansas.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) C. R. Wiggins

(Address) Rupert Idaho

15. Filed Dec. 3 1920 E. E. Ehmore, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Nov (Month) 14 (Day) 1915 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Nov. 13 1920, to Nov. 14 1920, that I last saw h[illegible] alive on Nov 14 19....., and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows: Premature Birth

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. Killen M. D.

19..... (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Rupert Cemetery — **DATE OF BURIAL**: Nov 14 1920

20. **UNDERTAKER**: W. A. Goodman — **ADDRESS**: Rupert Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

32305

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
Registration District No. 92
County of Latah
Primary Registration District No. 2170
City of Juliaetta (No. ....., St.)
File No. 6
Registered No. 9
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William H. Hughes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (or Widowed)

6. DATE OF BIRTH: May (Month) 17 (Day) 1864 (Year)

7. AGE: 56 yrs. 5 mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: William Hughes

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Susie Darby

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. H. Hughes.
(Address) Juliaetta Idaho

15.
Filed 10-13 1920
E. E. Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1920 to Oct 12 1920
that I last saw him alive on Oct 11 1920
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Double Lobar Pneumonia
Myocarditis
(Duration) ..... yrs. ..... mos. 7 ds.
Contributory (Secondary)
(Duration) ..... yrs. 1 mos. ..... ds.
(Signed) Ella M. Hanawell M. D.
Oct 17 1920 (Address) Juliaetta

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cakesdale Wn. DATE OF BURIAL: 10-15 1920

20. UNDERTAKER: L. W. Stoddard ADDRESS: Uniontown

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92 — 32308

Primary Registration District No. 2170

File No. 6

Registered No. 10

1. **PLACE OF DEATH**

County of Nez Perce

City of Cameron (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Evelina Theresa Neumann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Female

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED**: Infant (Write the word.)

6. **DATE OF BIRTH**: Oct. (Month) 24 (Day) 1920 (Year)

7. **AGE**: ..... Yrs. 1 Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Cameron Idaho.

10. **NAME OF FATHER** Fred W. Neumann.

11. **BIRTHPLACE OF FATHER** (State or Country) Minn.

12. **MAIDEN NAME OF MOTHER** Ida E. Mielke

13. **BIRTHPLACE OF MOTHER** (State or Country) Minn

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) F. W. Neumann

(Address) Cameron

15. Filed 11-29 1920 — E. E. Watts, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Nov. (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920 to Nov 26 1920 that I last saw her alive on Nov. 26 1920 and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Accidental

..... (Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Stoneburner M.

1920 (Address) Leland Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. [redacted] days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Cameron — **DATE OF BURIAL**: Nov 27 1920

20. **UNDERTAKER**: R. M. Smith — **ADDRESS**: Leland Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 32307
Registered No. 260

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. 0208, 22 St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha M Case

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov 4 (Month) (Day) 1855 (Year)

7. AGE: 65 Yrs. Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): South Carolina

10. NAME OF FATHER: Alexandra Smith

11. BIRTHPLACE OF FATHER (State or Country): South Carolina

12. MAIDEN NAME OF MOTHER: Tebitha Kames

13. BIRTHPLACE OF MOTHER (State or Country): South Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S R Case
(Address) 0208 - 22nd

15. Filed Dec 6 - 1920 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1920, to Nov. 13 1920 that I last saw her alive on Nov. 6 1920 and that death occurred on the date stated above, at 4 00 P M.

The CAUSE OF DEATH* was as follows:

Anaemia

(Duration) Several weeks Yrs. mos. ds.

Contributory (Secondary) Abdominal carcinoma

(Duration) Several yrs. mos. ds.

(Signed) L J Cukkin M. D.

11/14 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Cemetery — DATE OF BURIAL: Nov 14 1920

20. UNDERTAKER: W B Williamson — ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 32308
Registered No. 561

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. White Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christ Torstenson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Apr (Month) 16 (Day) 1896 (Year)

7. AGE: 24 Yrs. 4 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Howel Torkenson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R C Robison
(Address) Clarkston Wash

15.
Filed Dec 6 1920 Swan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3rd 1920, to Nov 13th 1920 that I last saw him alive on Nov 13th 1920 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis,
Chronic Pulmonary,
(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. T. Harris M. D.
11/13/1920 (Address) Lewiston, Ida

*State the *Disease Causing Death*; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clarkston Wash
DATE OF BURIAL: Nov 14 1920

20. UNDERTAKER: R. W Hayden
ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 9

Primary Registration District No. 1007

File No. 32310

Registered No. 363

County of Nez Perce

City of Lewiston (No. 146, 9th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lavina Pickman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied, AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Wh.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Apr 3 1853 (Month) (Day) (Year)

7. AGE: 65 Yrs. 10 Mos. 21 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Samuel Pickman

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Polly Ann

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L J Pickman

(Address) Culdy Sta.

15. Filed Dec 6 1920 Susan E Burns Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1920 to Nov 24 1920 that I last saw h[illegible] alive on Nov 23 1920 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

apoplexy, Bronchopneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. L. White M. D.

Nov 24 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho

DATE OF BURIAL 1920

20. UNDERTAKER: W B Williamson

ADDRESS: Lewiston Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32311

Registered No. 36

If death occurs away from usual residence, give facts called for under special information.

1. PLACE OF DEATH. Registration District No. 26

County of Owyhee Primary Registration District No. 2064

City of Mallard (No. , St.)

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Stephen Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Male	White	Married

6. DATE OF BIRTH Apr. (Month) 1 (Day) 1854 (Year)

7. AGE 66 yrs. 7 mos. 4 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Stephen Wright

11. BIRTHPLACE OF FATHER (State or Country) W Va

12. MAIDEN NAME OF MOTHER Lucy Fatterny

13. BIRTHPLACE OF MOTHER (State or Country) N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lavern Wright
(Address) .....

15. Filed Dec 6 1920 R M Warner M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Nov (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 6 1920 to Nov 4 1920 that I last saw h[im] alive on Nov 4 1920 and that death occurred on the date stated above, at 3:30 am

The CAUSE OF DEATH* was as follows:

Septic pharyngitis

(Duration) yrs. 4 mos. ds.

Contributory (Secondary) Septicemia

(Duration) yrs. mos. ds.

(Signed) R. M. Warner M. D.

19 (Address) Mallard, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pleasant View	Nov 7 1920

20. UNDERTAKER J. Guy Benson ADDRESS Mallard

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2064
File No. 32312
Registered No. 37

1. PLACE OF DEATH.
County of Oneida
City of Malad (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ada Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED.
Female	White	~~(Write word)~~

6. DATE OF BIRTH
Mar. (Month) 11 (Day) 1906 (Year)

7. AGE
14 yrs. 8 mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Malad

10. NAME OF FATHER ~~Hezekiah~~ Jos. M. Jones,

11. BIRTHPLACE OF FATHER (State or Country) Ogden Utah

12. MAIDEN NAME OF MOTHER Margret Thomas

13. BIRTHPLACE OF MOTHER (State or Country) Brigham Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Margaret Jones.
(Address) Malad Oneida Co Idaho

15.
Filed Dec 5 1920 R. W. Miller M.D.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 18 1920 to Nov 23 1920 that I last saw h.m alive on Nov. 23 1920, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) yrs. mos. 5 ds.
Contributory (Secondary) Blow on head.
(Duration) yrs. mos. ds.
(Signed) J. M. Kerns M. D.
19 (Address) Malad Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191..

20. UNDERTAKER J. Guy Benson | ADDRESS Malad Ida

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 26
Primary Registration District No. 2061
File No. 22213
Registered No. 38

1. PLACE OF DEATH
County of Oneida
City of Malad
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Falles

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Widowed

6. DATE OF BIRTH: Sept. (Month) 24 (Day) 1834 (Year)

7. AGE: 86 Yrs. 2 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: William H Thomas

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Anna Williams

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Julian Hayes
(Address) Malad Ida

15. Filed Dec 5 1920 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1919, to 10/14/1920, that I last saw h[illegible] alive on 10/14/1920, and that death occurred on the date stated above, at [illegible] M.
The CAUSE OF DEATH*, was as follows:
Senile decay
(Duration) / Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. M. Keyes M. D.
1920 (Address) Malad Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Ida — DATE OF BURIAL: Nov. 26 1920

20. UNDERTAKER: W. E. Johnson — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 130
Primary Registration District No. Homedale 2nd
File No. 32514
Registered No. 141

1. PLACE OF DEATH
County of Owyhee
City of Homedale
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 56 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Herder
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Michigan

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Williams
(Address) Homedale, Ida.

15. Filed Dec. 7 — 1920
John S. Meyers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1920 to Dec 3 1920 that I last saw him alive on Dec 3 1920 and that death occurred on the date stated above, at 3:30 P.M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Simeon Hopper M. D.
19..... (Address) Homedale Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Canyon Hill	12-7 1920
20. UNDERTAKER: C. V. Peckham	ADDRESS: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 2009
(No. ..... , ... St.)

File No. 32315
Registered No. .....

1. PLACE OF DEATH
County of Payette
City of Falk Store
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lorenzo L. Frasier

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 18 (Day) 1875 (Year)

7. AGE: 45 Yrs. 4 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hamilton Co Neb

10. NAME OF FATHER: Geo Frasier

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Anna Hansel

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L L. Frasier
(Address) Falk Store Ida

15. Filed Nov 4 1920
Wm J. Drysdale
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-8- 1920 to Nov 2 1920
that I last saw him alive on Nov 1 1920,
and that death occurred on the date stated above, at 9 PM.
The CAUSE OF DEATH* was as follows:
Typhoid

(Duration) ..... Yrs. ..... mos. 25 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm J Drysdale M. D.
11-2-1920 (Address) New Plymouth

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery Boise Ida
DATE OF BURIAL: 11/4 1920

20. UNDERTAKER: Schreiber & Heidenfelder
ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2130
Primary Registration District No.
File No. 32316
Registered No.

1. PLACE OF DEATH.
County of Payette
City of Fruitland
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Simott

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1920 (Year)

7. AGE: ✓ yrs. ✓ mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Fruitland Idaho

10. NAME OF FATHER: Geo Simott

11. BIRTHPLACE OF FATHER (State or Country): Ore

12. MAIDEN NAME OF MOTHER: Daisy Voyles

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo Simott
(Address) Fruitland Idaho

15. Filed Oct 20 – 1920 C. C. Paxton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 18 1920 to Oct 20 1920 that I last saw her alive on Oct 18 1920 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Icterus Neonatorum

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

10/20 1920 (Signed) William J Wiese M. D.
(Address) Ontario Ore

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: Oct 21 1920

20. UNDERTAKER: Glenn C Landon
ADDRESS: Payette Idaho

SYMS-YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2130
Primary Registration District No.
File No. 32317
Registered No.

1. PLACE OF DEATH.
County of Payette
City of Fruitland (No. St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas C Powell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Jan (Month) 9 (Day) 1854 (Year)

7. AGE: 65 yrs. 10 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: C. K. Powell

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry S. Powell
(Address)

15. Filed Nov 19, 1920 C. C. Payton Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1920 to Nov 15 1920 that I last saw h[illegible] alive on Nov 15 1920 and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

11/18 1920 (Signed) William H Wells M. D.
(Address) Ontario, Ore.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? Do not know

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Ontario Ore	Nov 18 1920

20. UNDERTAKER	ADDRESS
O. N. Adair	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of Fruitland
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2130
Primary Registration District No.
(No. ..., ... St.)

File No. 32318
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francis Daniel J Brady

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
May June 6 1920
(Month) (Day) (Year)

7. AGE
— yrs. 5 mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Frank Brady

11. BIRTHPLACE OF FATHER (State or Country) Mass.

12. MAIDEN NAME OF MOTHER Catherine Hardman

13. BIRTHPLACE OF MOTHER (State or Country) Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Brady
(Address) Fruitland Idaho

15.
Filed Nov 30 1920 C C Payton
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov 30 - 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1920 to Nov 30 1920
that I last saw him alive on Nov 29 1920
and that death occurred on the date stated above, at 8 P.M.
The CAUSE OF DEATH* was as follows:
Broncho Pneumonia

(Duration) ... yrs. ... mos. 5 ds.
Contributory (Secondary)
(Duration) ... yrs. 2 mos. ... ds.
(Signed) C. C. Payton M. D.
11/30 1920 (Address) Fruitland

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days.
Where was disease contracted if not at place of death? —
Former or usual residence —

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Dec 1 1920

20. UNDERTAKER	ADDRESS
J N Adair	Payette Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ..... St.)

File No. 32319
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth King

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Widowed

6. DATE OF BIRTH: July (Month) 18 (Day) 1831 (Year)

7. AGE: 89 yrs. 2 mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Tenn

10. NAME OF FATHER: — Ruff

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. B. Pence
(Address) Payette

15. Filed Oct 5 1920 191 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1920 to Sept 26 1920, that I last saw h er alive on Sept 25 — 1920, and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:
Enteritis 3 or 4 weeks
Arteriosclerosis
(Duration) many yrs. mos. ds.
Contributory (Secondary) Senility
(Duration) many yrs. mos. ds.
(Signed) Wm T. Hyndale M. D.
9-27-20 19 (Address) Near Emmett Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho | DATE OF BURIAL: Sept 28 1920

20. UNDERTAKER: C. A. Eddins | ADDRESS: Payette

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING.

BYMS - YORK CO., PTRS. & BDRS. 19750

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Payette

City of Payette

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

(No. ....., ... St.)

File No. 33220

Registered No. 38

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Coates

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR, DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov 3 (Month) 3 (Day) 1920 (Year)

7. AGE: ~ Yrs. ~ Mos. ~ ds. IF LESS than 1 day how many 7 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Payette Ida

10. NAME OF FATHER: Earl J Coates

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Bertha L Shuck

13. BIRTHPLACE OF MOTHER (State or Country): Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Earl J Coates.

(Address) Payette Idaho

15. Filed Nov 5 1920 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct Nov 3 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 11-3 1920, to Nov 3 11-3 1920, that I last saw her alive on Nov 11-3 1920, and that death occurred on the date stated above, at 4:20 P.M.

The CAUSE OF DEATH* was as follows:

Blue Baby, 7 mo.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J L McDonald M. D.

11-3 1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	Nov 3 1920
20. UNDERTAKER	**ADDRESS**
Glenn C Landon	Payette Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1005
(No. 5, ... St.)

File No. 32321
Registered No. 220
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank M Powell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Mar (Month) 19 (Day) 857 (Year)

7. AGE: 63 yrs. 7 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John W. Powell

11. BIRTHPLACE OF FATHER (State or Country): Tenn

12. MAIDEN NAME OF MOTHER: McBride

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Powell Jr.
(Address) Payette Ida

15. Filed Nov. 13/1920 191... J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1920 to Nov 4 1920, that I last saw h[illegible] alive on Nov 4 1920 and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Lung inflamation

(Duration) ..... yrs. ..... mos. 26 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

19... (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida | DATE OF BURIAL: Nov 5 1920

20. UNDERTAKER: D. Nadair | ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
(No. ..... St.)

File No. 32322
Registered No. 40

1. PLACE OF DEATH
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ben Coffey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 7 (Day) 1887 (Year)

7. AGE: 33 Yrs. 10 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ino

10. NAME OF FATHER: Isaac M Coffey

11. BIRTHPLACE OF FATHER (State or Country): North Car

12. MAIDEN NAME OF MOTHER: Emma Brooks

13. BIRTHPLACE OF MOTHER (State or Country): Ino

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Glenn Coffey
(Address) Payette Idaho

15. Filed Nov 13/1920 19.... J.C. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: Gunshot wound of heart
Suicide

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J.C. Woodward M. D.
10/10/1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	Oct 10 1920
20. UNDERTAKER: Glenn C Landon	ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ..... , ... St.)

File No. 33223
Registered No. 27
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. Allen Rose

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: May (Month) 9 (Day) 1919 (Year)

7. AGE: 1 yrs. 4 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: C. A Rose

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Stella McCullough

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas A Rose
(Address) Payette Ida

15. Filed Nov 20 1920. 191 J. C. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 7, 1920 to Sept 10 1920 that I last saw him alive on Sept 10, 1920 and that death occurred on the date stated above, at 7:00 P.M.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.

9/17/1920. (Address) Payette Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida DATE OF BURIAL: Sept 12 1920

20. UNDERTAKER: D. K. Adair ADDRESS: Payette Ida

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 36024
Registered No. 42

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harald Hurd
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 15 (Day) 1920 (Year)

7. AGE: 0 Yrs. 1 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Clyde Hurd

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Effie Adams

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde Hurd
(Address) Payette Ida

15. Filed Nov 20 1920 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 15 1920, to Sept 21 1920, that I last saw him alive on Sept 21 1920, and that death occurred on the date stated above, at 4 00 P.M.

The CAUSE OF DEATH* was as follows:

Marasmus

(Duration) ..... Yrs. ..... mos. 30 ds.

Contributory (Secondary) Premature birth

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.

9/24/1920 (Address) Payette, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida — DATE OF BURIAL: Sept 21 1920

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 22085
Registered No. 43

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William George Pennington
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: June 15 (Month) (Day) 1847 (Year)

7. AGE: 73 Yrs. 4 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher (retired 3 yrs)
(b) General nature of industry, business or establishment in which employed (or employer): Cattle & Hay.

9. BIRTHPLACE (State or Country): Canada.

10. NAME OF FATHER: Thomas Pennington

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Anna Bridges

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs B F Pennington
(Address) Payette Idaho

15. Filed Nov 20 1920 J C Woodward
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October 17 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 26 1920 to Oct 17 1920 that I last saw h[illegible] alive on Oct 17 1920 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Cerebral Haemorrhage

(Duration) ..... Yrs. ..... mos. 52 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J C Woodward M. D.
10/18/1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	Oct 18 1920
20. UNDERTAKER	ADDRESS
Glenn C Landon	Payette Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 22326
Registered No. 244

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edith Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write this word.)

6. DATE OF BIRTH: April (Month) 8 (Day) 1918 (Year)

7. AGE: 2 Yrs. 6 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Payette Idaho

10. NAME OF FATHER: John Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Lucy Herron

13. BIRTHPLACE OF MOTHER (State or Country): Tenn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): John Johnson
(Address): Payette Idaho

15. Filed Nov 20 1920 J. C. Woodward
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920, to Oct 25 1920 that I last saw her alive on Oct. 25 1920, and that death occurred on the date stated above, at 5-00 A.M.

The CAUSE OF DEATH* was as follows:
Enteritis - colitis

(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. H. Avery M. D.
10/25/1920 (Address) Payette, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: Oct 26 1920

20. UNDERTAKER: Glenn E Landon
ADDRESS: Payette Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 4

County of Payette Primary Registration District No. 1008

City of Fruitland (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

File No. 32027

Registered No. 45

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Celia A. Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH: July (Month) 29 (Day) 1862 (Year)

7. AGE: 58 yrs. 3 mos. 25 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Wm A Sanford

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Ruth Alverson

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ruth O. Van der Vare

(Address) Payette RFD 1

15. Filed Nov 29 1920 J C Woodward Local Registrar

a MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17, 1920 to Nov 23, 1920 that I last saw h[illegible] alive on Nov 23, 1920 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) — yrs. — mos. 12 ds.

Contributory (Secondary) —— (Duration) — yrs. — mos. — ds.

(Signed) C. E. Paxton M. D.

(Address) Fruitland Ida

Nov 25 1920

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 7 days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? At her home

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Payette Ida | DATE OF BURIAL: Nov 26 1920

20. UNDERTAKER: [illegible] | ADDRESS: Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 33328
Registered No. 46

1. PLACE OF DEATH.
County of Latah
City of Latah
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hugh Shearer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH
Nov (Month) 17 (Day) 1881 (Year)

7. AGE
39 yrs. ~ mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER James Shearer

11. BIRTHPLACE OF FATHER (State or Country) Scotland

12. MAIDEN NAME OF MOTHER Jeanette Lang

13. BIRTHPLACE OF MOTHER (State or Country) Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. J. Shearer
(Address) Payette Ida

15.
Filed Nov 29 1920 191 J. O. Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at 4:00 P M.

The CAUSE OF DEATH* was as follows:
Gunshot wound in left breast. Self inflicted.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. F. Knight, Coroner M. D.
11/24/1920 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Nov 26 1920
20. UNDERTAKER	ADDRESS
H. Adams	[illegible]

SYMS - YORK CO., PTRS. & BORS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

32329

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 25

Primary Registration District No. 2072

File No. 3

County of Power

City of American Falls (No. ....., ... St.)

Registered No. 116

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melvin Ross

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept (Month) 24 (Day) 1840 (Year)

7. AGE: 80 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): ~~Ills~~ Tennessee

10. NAME OF FATHER: Jackson Ross

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Lara Smith

13. BIRTHPLACE OF MOTHER (State or Country): Not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ellen Ross

(Address)

15. Filed 12 - 3 1920 R. J. Noth Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 27 1920 to Nov 29 1920, that I last saw him alive on Nov 29 1920 and that death occured on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Richard J. Noth M. D.

Nov 30 1920 (Address) American Falls Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ririe, Idaho

DATE OF BURIAL: Dec 2 1920

20. UNDERTAKER: [illegible]

ADDRESS: Am Falls Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

32330

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Power

City of Amer. Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 25

Primary Registration District No. 2072

(No. ....., ... St.)

File No. 3

Registered No. 109

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl W. Kite

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
Male	white	Single

6. DATE OF BIRTH: Oct. (Month) 2 (Day) 1892 (Year)

7. AGE: ..... yrs. 1 mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Arthur J. Kite

11. BIRTHPLACE OF FATHER (State or Country) Neb.

12. MAIDEN NAME OF MOTHER Mary E. Sayer

13. BIRTHPLACE OF MOTHER (State or Country) Neb.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur J. Kite
(Address) Amer. Falls.

15.
Filed 11 — 4 1912 R. F. Nolte
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 11 (Month) — 3 (Day) 1912 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 12 1912, to Nov. 3, 1912, that I last saw h.im alive on 11 2 1912, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:
Acute endocarditis
following an
unknown infection.
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Richard J. Nolte M. D.
11—3 1912 (Address) Amer Falls, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Falls. View Cem.	11 — 4 1912

20. UNDERTAKER	ADDRESS
A. W. Davis	Amer Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

32331

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. 50

Registration District No. 10
Primary Registration District No. 1011
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jos Cyotte

PERSONAL AND STATISTICAL PARTICULARS

3. SEX male

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) M

6. DATE OF BIRTH. ..... (Month) ..... 1 ..... (Day) ..... (Year)

7. AGE 52 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Francis Cyotte

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Louise Flamon

13. BIRTHPLACE OF MOTHER (State or Country) Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P J Cyotte
(Address) Coeur d'Alene Park

15. Filed Sept 11 1920 — J L Jones, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 8 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 4 1920 to ..... 191...
that I last saw h.. alive on Sept 4th 191....
and that death occurred on the date stated above, at ....,....M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) James R Bean M. D.
9/10 1920 (Address) Wallace

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wallace Ida — **DATE OF BURIAL** Sept 11 1920

20. UNDERTAKER B G Worrell — **ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

32339 State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123
Primary Registration District No. 2701
File No. 36
Registered No.

1. PLACE OF DEATH
County of Shoshone
City of Interstate Mine (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Lorius
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH
..... (Month) ..... (Day) 1 (Year)

7. AGE
40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE
(State or Country)

10. NAME OF FATHER No

11. BIRTHPLACE OF FATHER
(State or Country) formerly

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Sept 21st 1920 Geo. D Lester
Local Registrar

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Sep. 19 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sep 19 1920, to Sep 19 1920, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Suicide, by Shooting self with shot gun

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. D Lester M. D.
9/21 1920 (Address) Kellogg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	9/22 1920
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32333

Registered No. 52

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 10

Primary Registration District No. 1014

(No. Wallace Hospital)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wyllys Lund Lucas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	white	married

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE

41 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Foreman Steel Mill

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Vermont

10. NAME OF FATHER Edward F. Lucas

11. BIRTHPLACE OF FATHER

(State or Country) New Hampshire

12. MAIDEN NAME OF MOTHER Mary Smith

13. BIRTHPLACE OF MOTHER

(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Wyllys L. Lucas

(Address) Wallace Idaho

15. Filed Oct 21 1920 F. L. Jones Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

October (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 17 1920 to Oct 19 1920, that I last saw h. alive on Oct 19 1920, and that death occured on the date stated above, at 12:25 P.M.

The CAUSE OF DEATH* was as follows:

Abscess of Rt Lung

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm. T. Smith M. D.

10/22/20 19 (Address) Wallace Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Genesee Idaho

19. PLACE OF BURIAL OR REMOVAL Spokane Wash. DATE OF BURIAL Oct 25 1920

20. UNDERTAKER Harry Thompson ADDRESS Wallace

N. B. — [illegible] MARGIN RESERVED FOR BINDING [illegible] WITH UNFADING INK—THIS IS A PERMANENT RECORD. [illegible] should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYNS - YORK CO., PTRS. & BDRS. 24658

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH.

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

Registration District No. 70

Primary Registration District No. 10 11

(No. Court House St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Wells Woods

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 22334

Registered No. 54

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 79 Yrs. 9 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Judge District

(b) General nature of industry, business, or establishment in which employed (or employer): 1st. Court.

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: James N. Woods.

11. BIRTHPLACE OF FATHER (State or Country): New Hampshire

12. MAIDEN NAME OF MOTHER: Cathrine Wells.

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs. Harry Allen

(Address) Wallace Ida

15. Filed Nov 11 1920 F. L. Swindig Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 10th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 14 1920, to Nov 10th 1920, that I last saw h. im alive on Nov 10th 1920 and that death occured on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) Cerebral Thrombosis

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) Wm. T. Lewis M. D.

11/14/20 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: Nov. 12 1920

20. UNDERTAKER: Harry Thompson ADDRESS: Wallace Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 76

Primary Registration District No. 601

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32235

Registered No. 56

1. PLACE OF DEATH.

County of Shoshone

City of Wallace (No. [illegible] Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Ross Wood

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) (Year)

7. AGE: 74 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: Elic C. Wood

11. BIRTHPLACE OF FATHER (State or Country): Vermont

12. MAIDEN NAME OF MOTHER: Elizabeth Ross

13. BIRTHPLACE OF MOTHER (State or Country): Pa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. M. C. Wood

(Address) Gem Idaho

15. Filed Nov 15 20 F L Jenkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1920 to Nov 14 1920, that I last saw h[illegible] alive on Nov 14 1920, and that death occured on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) Yrs. mos. 9 ds.

Contributory (Secondary)

(Duration) Yrs. mos. ds.

(Signed) Dr Mowery M.D.

19 (Address) Wallace Ida

11/15/20

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.) 1 hr 15 mins

At place of death ...yrs ...mos ...days In the State ...yrs ...mos ...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Murray Ida. DATE OF BURIAL: Nov 16 1920

20. UNDERTAKER: C C Nordlie ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

32336

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 70

Primary Registration District No. 1011

File No. .....

County of Shoshone

City of Wallace (No. ..... St.)

Registered No. 53

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine A Connors

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fmal

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Mar (Month) 28 (Day) 1872 (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Thomas Mather

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Wheeler

13. BIRTHPLACE OF MOTHER (State or Country): France

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Arthur H Connors Sr.

(Address) Mullan, Idaho

15. Filed Nov 8 1920 F L Dunn Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1920, to Nov 7 1920, that I last saw her alive on Nov 7 1920, and that death occured on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Acute peritonitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. R. Dunn M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. | DATE OF BURIAL: 11/8 1920

20. UNDERTAKER: Hartell Co | ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 70
Primary Registration District No. 1041
(No. 204 Pine Street St.)

File No. 32337
Registered No. 5

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Wallis Graham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH. (Month) (Day) (Year): 1

7. AGE: 80 Yrs. 11 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Andrew Graham

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Joanna Monroe

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Miss Ruth Graham
(Address) Wallace Idaho 204 Pine St.

15. Filed Nov 26 1920 F. L. [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1920 to Nov 25 1920, that I last saw h[illegible] alive on Nov 22 1920 and that death occured on the date stated above, at 10a M.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(Duration) 20 Yrs. mos. ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) Dr. Mowery M. D.
(Address) Wallace Ida

26 1920

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence: Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Idaho — DATE OF BURIAL: Nov 27 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

EVANS - YORK CO., PTRS. & BDRS. 24858

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH.

County of Shoshone

Near City of Brown Creek

Registration District No. [illegible]

Primary Registration District No. 7700

(No. Near Brown Creek St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Anne E. Nyos

BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32338

Registered No. 57

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH. (Month) (Day) 1 (Year)

7. AGE: 30 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Day Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: not given

11. BIRTHPLACE OF FATHER (State or Country): Norway.

12. MAIDEN NAME OF MOTHER: not given

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Ira Nelson

(Address) Spokane Wash.

15. Filed OCT 11 1920 H C Mowe[illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 6 d (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Crushed by Rolling log.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Accident

Instantaneous Duration ..... yrs. ..... mos. ..... ds.

(Signed) Geo. N. Walker Justice of the Peace & ex officio Coroner

Oct 9 1920 (Address) Wallace Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence Spokane Wash.

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash | DATE OF BURIAL: Oct 9 1920

20. UNDERTAKER: Tracy Thompson | ADDRESS: Wallace Ida

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32229
Registered No. 32

1. PLACE OF DEATH
County of Teton
City of Dales
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. , St.)

2. FULL NAME Unnamed

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write word.)

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Elmer Farbush

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Blanche Merkley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Elmer Farbush
(Address) Dales Idaho

15.
Filed ..... 19.....
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 14 1920, to Nov 15 1920, that I last saw h[illegible] alive on Nov 15 1920 and that death occurred on the date stated above, at [illegible] P.M.
The CAUSE OF DEATH* was as follows:
Premature birth
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Chas J Martin M. D.
Nov 15 1920 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
	Nov 16 1920
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 240
Registered No. 31

1. PLACE OF DEATH
County of Teton
City of Driggs
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rena Magdalen Anderson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 15 (Day) 1900 (Year)

7. AGE: Yrs. ..... Mos. 19 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida Idaho

10. NAME OF FATHER: Samuel Magdalen Anderson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Elizabeth Knighton

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Samuel Magdalen Anderson
(Address) Driggs Ida

15. Filed 11/16 1920 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1920, to Nov 13 1920
that I last saw h alive on Nov 13 1920
and that death occurred on the date stated above, at 6P M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas J Marker M. D.
Nov 16 1920. (Address) Driggs Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chapin Idaho — DATE OF BURIAL: 11/12 1920

20. UNDERTAKER — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Twin Falls

City of Murtaugh

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36

Primary Registration District No.

(No. ..... St.)

File No. 32341

Registered No. 27

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** John Henry Anderson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	widowed

6. **DATE OF BIRTH**

Dec. (Month) 6 (Day) 1832 (Year)

7. **AGE**

87 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Tenn

10. **NAME OF FATHER** Dont know

11. **BIRTHPLACE OF FATHER** (State or Country) don't know

12. **MAIDEN NAME OF MOTHER** don't know

13. **BIRTHPLACE OF MOTHER** (State or Country) don't know

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs. Sam Cox.

(Address) Murtaugh Id. ho.

15. Filed Nov. 16, 1920 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**

Nov. (Month) 16 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 ..... to 19 ..... that I last saw h..... alive on 19 ....., had seen him professionally at times, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Davis M. D.

11/16 19 20 (Address) Kimberly, Ida.

*State the **Disease Causing Death**; or in deaths from **Violent Causes**, state (1) **Means of Injury**; and (2) whether **Accidental, Suicidal or Homicidal.**

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls, Ida.	11/17 1920
20. UNDERTAKER	**ADDRESS**
J. E. DeWill,	Twin Falls, Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 32642
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Viola B. Price

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: June (Month) 20 (Day) 1885 (Year)

7. AGE: 35 Yrs. 4 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Jacob A Garver

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Mary Butler

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. R. Garver
(Address) Hagerman Ida.

15. Filed Oct 22 1920 John F Coughlan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 16 1920, to Oct 18 1920, that I last saw h.e.r. alive on Oct 18 1920, and that death occurred on the date stated above, at 5 A.M.
The CAUSE OF DEATH* was as follows:

Duct General Peritonitis

(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Perforated Gangrenous Appendix
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) Chas. R. Scott M. D.
Oct 23 1920 (Address) Twin Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Ida.
DATE OF BURIAL ..... 19.....

20. UNDERTAKER: O. J. Freeman
ADDRESS Twin Falls

State of Idaho
BUREAU OF HEALTH

CERTIFICATE OF DEATH

42343

City of [illegible] (No. [illegible] St.) Registered No. [illegible]

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria B Nixon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: May (Month) 9 (Day) 1834 (Year)

7. AGE: 81 Yrs. 5 Mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Thomas Bonnes

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Grace Illenden

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Nixon
(Address) Twin Falls Ida.

15. Filed Oct 22 1920 John Y Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct — 1916, to Oct 16 1920 that I last saw h[illegible] alive on ..... 19..... and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Paralysis —

(Duration) 4 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H O Clouch M. D.

Oct 17 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Adrian Mich. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: J. P. Grossman ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 2211
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Kate M. Dodge

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH Feb (Month) 10 (Day) 1846 (Year)

7. AGE 74 Yrs. 8 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Texas

10. NAME OF FATHER John W Dodge

11. BIRTHPLACE OF FATHER (State or Country) N.Y.

12. MAIDEN NAME OF MOTHER Mary L. Dodge

13. BIRTHPLACE OF MOTHER (State or Country) N.Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jessie Smith
(Address) Twin Falls

15. Filed Oct 22 1920 John Houghlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 10 (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1908 to 10/18/ 1920
that I last saw h[illegible] alive on 10/17/ 1920
and that death occurred on the date stated above, at 2 p.m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(Duration) 12 Yrs. ..... mos. ..... ds.,
Contributory (Secondary) (Hypostatic) Pneumonia
(Duration) ..... yrs. ..... mos. 3 ds.

(Signed) W. G. Tibbs M. D.
10-22-1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: Oct 19 1920

20. UNDERTAKER: J. P. Sorensen
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 3295
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John E Myers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Married

6. DATE OF BIRTH
Feb 9 (Month) (Day) 1874 (Year)

7. AGE
46 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work MD Doctor
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) MO

10. NAME OF FATHER
A L Myers

11. BIRTHPLACE OF FATHER
(State or Country) Ind

12. MAIDEN NAME OF MOTHER
Hannah Snyder

13. BIRTHPLACE OF MOTHER
(State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna Allison
(Address) Cheyenne Wyo

15.
Filed Nov 12 1920 J. F. Longmire
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
11 (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/5 1920, to 11/10 1920 that I last saw him alive on 11/10 1920, and that death occurred on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:
Perforating gunshot wound abdomen

(Duration) Yrs. mos. 3½ ds.
Contributory (Secondary) General peritonitis
(Duration) yrs. mos. 3 ds.

(Signed) W H Fike M. D.
11/10/1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Portland Ore — DATE OF BURIAL: 19

20. UNDERTAKER: E E Wood — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of ( )

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ....., ... St.)

File No. 9946

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Medra Earl

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: July 3 (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. 4 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) Laborer.

9. BIRTHPLACE (State or Country) Utah.

10. NAME OF FATHER D. L. Earl

11. BIRTHPLACE OF FATHER (State or Country) Mexico

12. MAIDEN NAME OF MOTHER Mildred Walker

13. BIRTHPLACE OF MOTHER (State or Country) Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. L. Earl

(Address) Box 2—So Twin Falls

15. Filed Nov. 6- 1920 J. F. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 3 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

& pneumococcic meningetis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F. Coughlin M. D.

19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Nov 6 1920

20. UNDERTAKER	ADDRESS
C. J. Grossenese	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 2085

(No. ..... St.)

File No. 32347

Registered No. .....

2. FULL NAME William Pereboom

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feb 15 — 1 (Month) (Day) (Year)

7. AGE: 56 Yrs. 8 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: William Pereboom

11. BIRTHPLACE OF FATHER (State or Country): Holland

12. MAIDEN NAME OF MOTHER: Katherine Eckoff

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Wm Pereboom

(Address) .....

15. Filed Nov 12 1920 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 11 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920, to Nov 11 1920, that I last saw him alive on Nov 7th 1920, and that death occurred on the date stated above, at 1 1/2 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John F. Coughlin M. D.

11-11 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idah — DATE OF BURIAL: Nov 13 1920

20. UNDERTAKER: F. E. Reard — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 10x5
File No. 3648
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Hattie A Reece
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow

6. DATE OF BIRTH: July 14 (Month) (Day) 1843 (Year)

7. AGE: 77 Yrs. 3 Mos. 18 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Conn

10. NAME OF FATHER: Marshall Mitchell

11. BIRTHPLACE OF FATHER (State or Country): Conn

12. MAIDEN NAME OF MOTHER: Roxa Carter

13. BIRTHPLACE OF MOTHER (State or Country): Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. E. F. George
(Address): R. 2 Twin Falls Ida.

15. Filed Oct 30 1920 John Y Coughlan Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to Oct 28 1920, that I last saw h[illegible] alive on Oct 27 1920 and that death occurred on the date stated above, at 6:10 P.M.
The CAUSE OF DEATH* was as follows:

Senility

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) W. A. Lutz M. D.
Oct 30 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: ~~Twin Falls Idaho~~ Twin Falls
DATE OF BURIAL: 11-1 1920

20. UNDERTAKER: J E Everett
ADDRESS: Twin Falls

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 22251
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Tracy Gauney Jr.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct 24 1920 (Month) (Day) (Year)

7. AGE: ....Yrs. ....Mos. ....ds.
IF LESS than 1 day how many 3 hrs. or ....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Innocent
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Twin Falls

10. NAME OF FATHER: Tracy Gauney

11. BIRTHPLACE OF FATHER (State or Country): Cal

12. MAIDEN NAME OF MOTHER: ~~Cora~~ Theas Mencho

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Tracy Gauney
(Address) Twin Falls Dea.

15. Filed Oct 25 1920 — John F Coughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 24 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920, to Oct 24 1920 that I last saw h.im alive on Oct 24 1920, and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:
Premature birth
....(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
....(Duration) ....yrs. ....mos. ....ds.
(Signed) John F. Coughlin M. D.
10-25 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Oct 25 1920

20. UNDERTAKER: J E Peart — ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Dr Newberry.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of " "

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37

Primary Registration District No. 1085

(No. ..... , ... St.)

File No. 22252

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Richard Arthur Stradley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 28 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls

10. NAME OF FATHER: N.A. Stradley

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Dorris Stiles

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) X N. A. Stradley

(Address) .....

15. Filed Nov. 6 1920

X [illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 28 1920, to Oct 30 1920, that I last saw h[illegible] alive on Oct 29 1920, and that death occurred on the date stated above, at 10m M.

The CAUSE OF DEATH* was as follows:

Not determined

"Convulsions"

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.

19..... (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls

DATE OF BURIAL: Nov 1 1920

20. UNDERTAKER: [illegible]

ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 36000
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

2. FULL NAME Mrs. E. Sieber

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. Feb (Month) 10 (Day) 1884 (Year)
7. AGE: 36 Yrs. 8 Mos. 18 ds. IF LESS than 1 day how many .... hrs. or .....min.?'
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
9. BIRTHPLACE (State or Country) Penn
10. NAME OF FATHER W G Sieber
11. BIRTHPLACE OF FATHER (State or Country) Penn
12. MAIDEN NAME OF MOTHER Mary Haldeman
13. BIRTHPLACE OF MOTHER (State or Country) Penn
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bertha Sieber
(Address) Filer
15. Filed Nov 13 1920 — A. A. Newberry, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 11-45
Nov (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1920 to Nov 13 1920
that I last saw h[illegible]m alive on Nov 13 1920
and that death occurred on the date stated above, at 11:45 P. M.

The CAUSE OF DEATH* was as follows:

Peritonitis
Typhoid Fever
(Duration) ..... Yrs. ..... mos. 21 ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
11/15 1920 (Address) Filer Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Freeport Ill — DATE OF BURIAL ..... 191...
20. UNDERTAKER — ADDRESS

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32354
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 78
Primary Registration District No. 2086
(No. ....., ... St.)

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James J Pittman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH. June (Month) 16 (Day) 1912 (Year)
7. AGE: 8 Yrs. 5 Mos. 2 ds. IF LESS than 1 day how many .... hrs. or .... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country) Nevada
10. NAME OF FATHER J N Pittman
11. BIRTHPLACE OF FATHER (State or Country) Texas
12. MAIDEN NAME OF MOTHER Anna Brooks
13. BIRTHPLACE OF MOTHER (State or Country) Nebraska
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. N. Pittman
(Address) Filer
15. Filed Nov 19 20 191.... A A Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 4-55
Nov (Month) 18 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov. 14 20 191.... to Nov 18 20 191...
that I last saw h.....alive on Nov 17 20 191...
and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:
Typhoid Fever
.....(Duration) ..... Yrs..... mos. 18 ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
Nov 18 20 (Signed) A A Newberry M. D.
19.... (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Roof Cemetery — DATE OF BURIAL Nov 19... 1920.
20. UNDERTAKER J E Clark — ADDRESS Filer

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 32355
Registered No. .....

1. PLACE OF DEATH
County of .....
City of .....
If death occurs away from usual residence, give facts called for under special nformation.

(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME, John F. Umphrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. Nov (Month) 15 (Day) 1861 (Year)
7. AGE: 58 Yrs. 11 Mos. 25 ds. IF LESS than 1 day how many .... hrs. or .....min.?'
8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer
9. BIRTHPLACE (State or Country) Michigan
10. NAME OF FATHER: Samuel Umphrey
11. BIRTHPLACE OF FATHER (State or Country): Canada
12. MAIDEN NAME OF MOTHER: Rachel Caster
13. BIRTHPLACE OF MOTHER (State or Country): Canada
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maude Umphrey
(Address) Filer
15. Filed Nov. 11 20 191.... A. A Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 11 (Day) 1920 (Year) @ 10-45 AM
17. I HEREBY CERTIFY, That I attended deceased from Nov 10 20 191..... to Nov 11 20 191...
that I last saw h.....alive on Nov 11 1920
and that death occurred on the date stated above, at 10 P.M.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

.....(Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Cerebral Hemorrhage
.....(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) A. A Newberry M. D.
Nov. 11 1920 (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer — DATE OF BURIAL: Nov 13 1920
20. UNDERTAKER: C Drake — ADDRESS: Filer Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

32356

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

2. FULL NAME Cornelia Jane Arnhart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. May (Month) 8 (Day) 1847 (Year)

7. AGE 73 Yrs. 5 Mos. 10 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Wife

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER J. C. Jennings

11. BIRTHPLACE OF FATHER (State or Country) Kentucky

12. MAIDEN NAME OF MOTHER Lucy Censelton

13. BIRTHPLACE OF MOTHER (State or Country) Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Arnhart
(Address) Filer

15. Filed Oct 18 20 1920 A. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920 to Oct 18 1920
that I last saw h[illegible] alive on Oct 17 1920
and that death occurred on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
.....19.... (Address) Filer Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death	yrs.	mos.	days.	In the State	yrs.	mos.	days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL I.O.O.F. Cemetery — DATE OF BURIAL Oct 19 1920

20. UNDERTAKER J. E. Drake — ADDRESS Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

32357

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. .....
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Lyda C. Roberts

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct (Month) 16 (Day) 1848 (Year)

7. AGE: 71 Yrs. 11 Mos. 27 ds.
IF LESS than 1 day how many .... hrs. or .... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Wife

9. BIRTHPLACE (State or Country) North Carolina

10. NAME OF FATHER Fred Long

11. BIRTHPLACE OF FATHER (State or Country) North Carolina

12. MAIDEN NAME OF MOTHER Caroline Holcomb

13. BIRTHPLACE OF MOTHER (State or Country) N Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Clara Sears
(Address) Filer

15. Filed Oct. 11 20 191.... A. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ..... Oct (Month) ..... 10 (Day) ..... 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1920 to Oct 10 1920
that I last saw h.. alive on Oct 9 1920.
and that death occurred on the date stated above, at 2 ... 9 M.

The CAUSE OF DEATH* was as follows:
Peritonitis
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Perforation D.U.O.D.
Gastric carcinoma
ulcer (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Dr. A. A. Newberry M. D.
.....19.... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Doots Cemetery — DATE OF BURIAL Oct 12 1920.

20. UNDERTAKER J. E. Drake — ADDRESS Filer

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 32558
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burley (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Julia Dorthy Lindau

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: July (Month) 1 (Day) 1835 (Year)

7. AGE: 85 yrs. 3 mos. 30 ds.
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Riga

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Riga

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Riga

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert Lindau
(Address) Burley Idaho

15. Filed Oct 30 1920 J. S. Murphy Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: October (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 1917, to Oct 30 1920 that I last saw her alive on Oct 29 1920 and that death occurred on the date stated above, at 1.15 A.M.

The CAUSE OF DEATH* was as follows:

Old age.
(no intercurrent disease)

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Asthenia

(Duration) ..... yrs. ..... mos. 5. ds.

(Signed) F. A. Irmen. M. D.

Oct 30 1920 (Address) Burley Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Olaveu Ida
DATE OF BURIAL: Oct 31 1920

20. UNDERTAKER: Hamer B Evans
ADDRESS: Burley Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17148

FORM V. S. No. 5-25 M 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2187
File No. 2239
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME E Louise Leland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed

6. DATE OF BIRTH: Nov. (Month) 22 (Day) 1849 (Year)

7. AGE: 70 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Daniel B. Foote.

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Euphemia Powell.

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. O. R. White
(Address) Burke, Idaho.

15. Filed 11-3 1920
J. Munson
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug. 15 1920, to Nov. 3 1920, that I last saw her alive on Oct. 26 1920, and that death occurred on the date stated above, at 7a M.
The CAUSE OF DEATH* was as follows:

Paralysis.

(Duration) ..... Yrs. 2 mos. 20 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. A. Marsh M. D.
Nov. 3 1920 (Address) Burke, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Oltoya Ill. | DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Wells & Perry | ADDRESS: Gooding Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 22260
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burley
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vera Margaret Lang

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 3rd (Day) 1904 (Year)

7. AGE: 16 Yrs. 9 Mos. 17 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: J. R. Lang

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Mary King

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Lang
(Address) Burley

15. Filed Nov. 17 1920
J. N. Murphy, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/3 1920, to 11/15 1920, that I last saw h. a. alive on 11/14 1920, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Acute Exhilaration of Heart.
(Duration) Yrs. mos. 5 ds.

Contributory (Secondary) Chronic endocarditis
(Duration) 2 yrs. 4 mos. ds.

(Signed) C. F. Engelbrecht M. D.
11/15 1920 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley — DATE OF BURIAL: 11/17 1920

20. UNDERTAKER: Homer B Evans — ADDRESS: Burley

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

M. C. Murphy

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2081
File No. 32361
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Philip Stanley Davidson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Feb. (Month) 12 (Day) 1901 (Year)

7. AGE: 19 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: James M. Davidson

11. BIRTHPLACE OF FATHER (State or Country): Ind.

12. MAIDEN NAME OF MOTHER: Ida Peasley

13. BIRTHPLACE OF MOTHER (State or Country): Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) M. N. Dick
(Address)

15. Filed Nov 18 1920 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/10 1920, to 11/17 1920
that I last saw h. in alive on 11/16 1920
and that death occurred on the date stated above, at 2:35 P.M.

The CAUSE OF DEATH* was as follows:
Skull fracture, Hemorrhage
accidental
Lacerating brain
Fractured left temporal bone
perforating (Duration) Yrs. ..... mos. 6 ds.
Contributory (Secondary) Primary Hemorrhage
was direct
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. Ross Clarke M. D.
11/18 1920 (Address) Buhl Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: 11/18 1920

20. UNDERTAKER: Hawley & Grigg — ADDRESS: Buhl Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 3087
File No. 32262
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ira Ben Bradley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: Sept (Month) 4 (Day) 1920 (Year)

7. AGE: Yrs. 2 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany Jan

10. NAME OF FATHER: Albert E Bradley

11. BIRTHPLACE OF FATHER (State or Country): Mont

12. MAIDEN NAME OF MOTHER: Inga Olsen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert E. Bradley
(Address) .....

15. Filed 11-26 1920
J. W. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/25 1920, to 11/25 1920, that I last saw h. alive on 11/25 1920, and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Atelectasis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) 6 to 10 weeks previous

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. F. McCampbell M.D.

11/26 1920 (Address) Burke Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burke Cemetery — DATE OF BURIAL: 11/26 1920

20. UNDERTAKER: Neville & Gregg — ADDRESS: Burke Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington

City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

File No. 32263

Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mary Pearl Peterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 16 (Day) 1916 (Year)

7. AGE: 4 Yrs. 3 Mos. 5 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Cambridge Ida

10. NAME OF FATHER: M A Peterson

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ruby Stonsfield

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lorenzo Peterson

(Address) Cambridge Ida

15. Filed 11/20/20 19 R. W. Coleman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 17 1920, to Oct 21 1920, that I last saw h.. alive on Oct 21 1920, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) Yrs. mos. 5 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. A. Winniman M. D.

10/22 1920 (Address) Cambridge, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: Oct 23 1920

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32264
Registered No.

1. PLACE OF DEATH

County of Washington
City of Cambridge
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. .....
Primary Registration District No. .....

2. FULL NAME Adelaine Favre

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: July (Month) 21 (Day) 1846 (Year)

7. AGE: 74 Yrs. 3 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Joseph Denoma

11. BIRTHPLACE OF FATHER (State or Country): Unascertained

12. MAIDEN NAME OF MOTHER: Unascertained

13. BIRTHPLACE OF MOTHER (State or Country): Unascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Felix J Favre
(Address) Cambridge Ida

15. Filed 11/20/20 19..... P M McNeman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1919, to Nov 2 1920, that I last saw her alive on Nov 2 1920, and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows: Acute Nephritis

(Duration) ..... Yrs. 2 mos. 10 ds.
Contributory (Secondary) Cerebral Hem.
(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) P M McNeman M. D.
19..... (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cambridge	Nov 5 1920

20. UNDERTAKER	ADDRESS
M J Hudelson	Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

File No. 22365
Registered No. .....

1. PLACE OF DEATH

County of Washington
City of Cambridge

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Lyman Baker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word.)

6. DATE OF BIRTH Aug (Month) 14 (Day) 1848 (Year)

7. AGE 72 Yrs. 2 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Preacher

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) NY

10. NAME OF FATHER Samuel B Baker

11. BIRTHPLACE OF FATHER (State or Country) Massachusetts

12. MAIDEN NAME OF MOTHER Unascertained

13. BIRTHPLACE OF MOTHER (State or Country) Unascertained

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) E C Baker

(Address) 1406 - W - 45 - Seattle Wn

15. Filed 11/10/20 19.... W. M. Anderson Jr. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920 to Nov 8 1920 that I last saw him alive on Nov 8 1920 and that death occurred on the date stated above, at [illegible] M.

The CAUSE OF DEATH* was as follows:

Heart failure

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Bright Disease

Don't Know. (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E A Williamson M. D.

11/8 1920 (Address) Cambridge Ida

*State the *Disease Causing Death*; or in deaths from **Violent Causes**, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Cambridge — **DATE OF BURIAL** Nov 11 1920

20. UNDERTAKER J A Anderson — **ADDRESS** Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2368

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
Registration District No. 86
Primary Registration District No. 2112
Registered No. 60
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Arthur H. Runnalls

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Dec (Month) 5 (Day) 1867 (Year)

7. AGE: 52 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: Thos. G. Runnalls

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Katie Pierce

13. BIRTHPLACE OF MOTHER (State or Country): N.H.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Runnalls
(Address) Van Alstyne [redacted]

15. Filed Sept 8 1920 — W. R. Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: September 8th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 3 1920, to Sept 8th 1920, that I last saw h— alive on Sept 8 1920, and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:
Strangulated hernia - right.

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Conant M. D.
9/8 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL ..... 19 .....

20. UNDERTAKER: Thos. McCann — ADDRESS Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Hamilton

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 52363
Registered No. 61

1. PLACE OF DEATH
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Earl W. Mangum

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 14 (Day) 1915 (Year)

7. AGE: 5 Yrs. 8 Mos. 28 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Frank Mangum

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Florence Kilpatrick

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. W. Mangum
(Address) Weiser Idaho

15. Filed Sept 17 1920 — W. R. Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 12th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 23rd 1920, to Sept-12th 1920, that I last saw h-- alive on Sept-12th 1920, and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:
Measles.
(Duration) ..... Yrs. ..... mos. 21 ds.
Contributory (Secondary) Pneumonia
(Duration) ..... yrs. ..... mos. 10 ds.
(Signed) W. R. Hamilton M. D.
9/12 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: Sept 13 1920

20. UNDERTAKER: Hoothain & McCann — ADDRESS: Weiser

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 32370
Registered No. 62

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rhoda A Palmer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 8 (Day) 892 (Year)

7. AGE: 28 Yrs. 11 Mos. 3 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: H H Smith

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Sarah Broaud

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W Palmer
(Address) Weiser

15. Filed Sept 11 1920 W. R. Hamilton Local Registrar
R. L. 66

SYMS-YORK CO. PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1 1920 to Sept 11 1920, that I last saw h.. alive on Sept 11 1920, and that death occurred on the date stated above, at 2.30 P.M.
The CAUSE OF DEATH* was as follows:
Appendicitis

(Duration) ..... Yrs. ..... mos. 11 ds.
Contributory (Secondary) Boat Upset Weiser River
(Duration) ..... yrs. ..... mos. 6 ds.

(Signed) W. R. Hamilton M. D.
9/13 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: Sept 13 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser, Ida

Hamilton

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
(No. ..... St.)

File No. 32271
Registered No. 63

1. PLACE OF DEATH
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Sybilla Woods

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 18 (Day) 1914 (Year)

7. AGE: 5 Yrs. 9 Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebr.

10. NAME OF FATHER: Thomas C Woods

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Jessie R Laird

13. BIRTHPLACE OF MOTHER (State or Country): Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos C Woods
(Address) Midvale Idaho

15. Filed Sept-19th 1920 — W R Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 18th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept-11th 1920, to Sept-18th 1920, that I last saw h.. alive on Sept-18th 1920, and that death occurred on the date stated above, at 10¼ M.

The CAUSE OF DEATH* was as follows:

Ileo-Colitis

(Duration) ... Yrs. ... mos. 7 ds.

Contributory (Secondary): Nephritis —

(Duration) ... yrs. ... mos. ... ds.

(Signed) W. R. Hamilton M. D.

9/19 1920. (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 9-19 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 2112

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32272

Registered No. 69

1. PLACE OF DEATH

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robbie Clara Woods

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Apr (Month) 15 (Day) 1919 (Year)

7. AGE: 1 Yrs. 5 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Shelbourn Kans

10. NAME OF FATHER: T. C. Woods

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Jesse R Laird

13. BIRTHPLACE OF MOTHER (State or Country): Nebr.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos C Woods

(Address) Middvale Idaho

15. Filed Sept 19th 1920

W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 19th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 11th 1920 to Sept 19th 1920 that I last saw h.. alive on Sept 19th 1920 and that death occurred on the date stated above, at 5:30 M.

The CAUSE OF DEATH* was as follows:

Uremia - Cystitis

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary) Malaria

(Duration) yrs. mos. ds.

(Signed) W. R. Hamilton M. D.

9/20 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Fellers or Cemetery

DATE OF BURIAL: Sept 20 1920

20. UNDERTAKER: Northam & McDaniel

ADDRESS: Weiser Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 22273
Registered No. 66

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Mikkelsen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Feb (Month) 1 (Day) 1 (Year)

7. AGE: 85 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. Mikkelsen
(Address) Cuprum Idaho

15. Filed Sept 28 1920 W. R. Hamilton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Found dead in bed. no
Doubt. old age had been
an invalid for 2 years
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. L. Northam Coroner M. D.
9-29 1920 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 9-29 1920

20. UNDERTAKER: Northam & McCain — ADDRESS: Weiser Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 56
Primary Registration District No. 1010.
File No. 52074
Registered No. 66

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME L Worth Sinclair
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 27 (Day) 1871 (Year)

7. AGE: 49 Yrs. 1 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: James Wilson

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Catherine Goodhart

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Sinclair
(Address) Council Bridge Idaho

15. Filed Sept 30th 1920 — W R Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 9 (Month) 27th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/25 1920 to 9/27 1920 that I last saw h— alive on 9/27/20 19..., and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Intestinal Obstruction
Strangulated right femoral hernia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Cavaney M. D.
9/30 1920 (Address) Weiser Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 9-30 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Hamilton

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 32375
Registered No. 67

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Coleman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH — — — 1
(Month) (Day) (Year)

7. AGE 57 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) Farmer

9. BIRTHPLACE —
(State or Country)

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER —
(State or Country)

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER —
(State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. A. Crawford
(Address) Weiser

15. Filed Sept 29th 1920 W. R. Hamilton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 28th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27th, 1920, to Sept 28th 1920, that I last saw h~~im~~ alive on Sept 28 1920 and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:
Chronic Cystitis
(Duration) Lingal yrs. ..... mos. ..... ds.
Contributory (Secondary) Sepsis & Retention
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. R. Hamilton M. D.
10/25 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Hillcrest Cemetery | DATE OF BURIAL 10-1 1920

20. UNDERTAKER Northam & McCann | ADDRESS Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32376

City of Weiser (No. ..... St.) Registered No. 67

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. L. Stamper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1862 (Year)

7. AGE: 57 Yrs. 11 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Stamper

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. L. Stamper
(Address) Weiser Ida

15. Filed Oct 2nd 1920 — W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 24 1920 to Sept 29 1920 that I last saw him alive on Sept 29 1920 and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary): Hypertensional tension.

(Duration) 0? yrs. ..... mos. ..... ds.

(Signed) Ernest O. Finney M. D.

10/1 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 10-2 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of this sheet.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Shoshone

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH

Registration District No. 86
Primary Registration District No. 2112
File No. 32377
Registered No. 64

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Agnes Hollenberg

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb (Month) 27 (Day) 1903 (Year)

7. AGE: 17 Yrs. 7 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: H B Hollenberg

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Catherine Mc Dermott

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H B Hollenberg
(Address) Weiser Ida Ho

15. Filed Sept 21st 1920
W. R. Hamilton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 19 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 11 to Sept 19 20 that I last saw h alive on Sept 19 20 and that death occurred on the date stated above, at 4 P.M.
The CAUSE OF DEATH* was as follows:

a Cerebral Hemorrhage
b
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Ruptured appendix
(Duration) 6 Yrs. ..... mos. 2 ds.
(Signed) H B Hollenberg M. D.
Oct 1920 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery
DATE OF BURIAL: 10-1 1920

20. UNDERTAKER: Northam McCann
ADDRESS: Weiser Ida

marshall

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 86

Primary Registration District No. 2010

(No. ..... St.)

File No. 32278

Registered No. 78

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Merril Bailey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Aug (Month) 6 (Day) 1918 (Year)

7. AGE: 2 Yrs. 1 Mos. 26 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Lloyd R Bailey

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Era B Ashby

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lloyd R Bailey

(Address) Weiser Ida

15. Filed Oct-14 19 20 — W R Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27, 1920, to Oct. 1, 1920, that I last saw h. alive on Oct 1, 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Dysentery.

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

Oct 14 1920 (Address) Spencer

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetry — DATE OF BURIAL: 10-4 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 32379
Registered No. 71

1. PLACE OF DEATH
County of Washington
City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wilber N. Hartley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Wht	Single

6. DATE OF BIRTH: Apr (Month) 26 (Day) 1905 (Year)

7. AGE: 15 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: B Dick Hartley

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Sally R Williamson

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B Dick Hartley
(Address) Weiser Ida Rt 5

15. Filed Oct 15th 1920 — W. R Hamilton — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 19 20 to Oct 3 19 20
that I last saw him alive on Oct 3 19 20
and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Accidental gun shot wound of head

4 hours (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) hemorrhage
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Cannon M. D.
Oct 15 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillcrest Cemetery	Oct 5 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Finney

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32380

Registered No. 72

Registration District No. 86

Primary Registration District No. 1010

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Washington

City of Weiser

2. FULL NAME Mrs Clara White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 8 (Day) 1867 (Year)

7. AGE: 53 Yrs. 8 Mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Nathan Hockett

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Elizabeth Cook

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Anna Raley.

(Address) Johnnett Ore

15. Filed Oct-7th 1920 W R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/5 1920 to 10/6 1920

that I last saw her alive on 10/6 1920

and that death occurred on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

Accidental Burns of Body.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Pulmonary Edema

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest O. Finney M. D.

10/9 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 2 days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Robinett Oregon

Former or usual residence Cambridge Ida

19. PLACE OF BURIAL OR REMOVAL: Compton

DATE OF BURIAL: 19

20. UNDERTAKER: Enfinette Bro ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 56

Primary Registration District No. 212

File No. 32281

Registered No. 59

PLACE OF DEATH

County of Washington

City of Weiser

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alberta Walton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: May (Month) 13 (Day) 1875 (Year)

7. AGE: 44 Yrs. 4 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Wm Walton

11. BIRTHPLACE OF FATHER (State or Country): Pa.

12. MAIDEN NAME OF MOTHER: Elizabeth Bowman

13. BIRTHPLACE OF MOTHER (State or Country): Ore

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Agnes A Hagans

(Address) Weiser Idaho

15. Filed Oct 9th 1920

W R Hamilton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/2 1920 to 10/7 1920 that I last saw her alive on 10/2 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ernest O Finney M. D.

10/9 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19.....

20. UNDERTAKER | ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 32382
Registered No. 74

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mark E Woods

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept. (Month) 20 (Day) 1848 (Year)

7. AGE: 35 Yrs. — Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lawyer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: D. H. Woods

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Emma E Ostrander

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. H. Woods
(Address) Boise Idaho R7D #2

15. Filed Oct 8 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/7/20 19..., to 10/8/20 19..., that I last saw h— alive on 10/8/20 19..., and that death occurred on the date stated above, at 6:09 M.

The CAUSE OF DEATH* was as follows:
Shock following
Laceration of abdominal Viscera
(Duration) ... Yrs. ... mos. 1 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) C C Cavaney M. D.
Oct 8 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Donnelly, Ida. DATE OF BURIAL: 10/10 1920

20. UNDERTAKER: Hoothan & McCann ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 81
Primary Registration District No. 1010
File No. 24383
Registered No. 70

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ethel May Kilbourne
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Oct (Month) 10 (Day) 1900 (Year)

7. AGE: 20 Yrs. 0 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Enos Kilbourne

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Laura Smith

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Flossie Johnson
(Address) Cambridge Idaho

15. Filed Oct 18th 1920
W R Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1920, to Oct 18 1920
that I last saw h[illegible] alive on Oct 17 1920
and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis Uremia

(Duration) [illegible] Yrs. mos. ds.
Contributory (Secondary) Pulmonary Tuberculosis
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) W W Hyndall M. D.
Oct 19 1920 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge Ida — DATE OF BURIAL: 10/18 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8 6
Primary Registration District No. 1010
File No. 32284
Registered No. 76

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ellen Kirby
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Nov 19 1847 (Month) (Day) (Year)

7. AGE: 73 Yrs. 6 Mos. 29 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: John Mozell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs W P Kirby
(Address) Boise Idaho

15. Filed 10/20/20 19 — H. R. Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 13 1920, to Oct 18 1920, that I last saw h.er alive on Oct 18 1920, and that death occurred on the date stated above, at 7 P M.
The CAUSE OF DEATH* was as follows:
Apoplexy
(Duration) Yrs. mos. 8 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) C B Lyster M. D.
1920 (Address) Weiser, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 10/20 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 32385
Registered No. 77

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eliza J. Hawthorn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	Wh	Widowed

6. DATE OF BIRTH: Sept. (Month) 29 (Day) 1839 (Year)

7. AGE: 81 Yrs. 2 Mos. 23 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Lorenzo D. Gill

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Eliza Edwards

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE ~~BEST OF~~ MY KNOWLEDGE
(Informant) M. L. Hawthorn
(Address) Emmett Idaho

15. Filed 10/23/20 19 ..... W. R. Knowlton
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920 to Oct 22 1920
that I last saw h[illegible] alive on Oct 22 1920
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) G. M. Walker M. D.
10/23 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerist Cemetry | DATE OF BURIAL: 10-29 1920

20. UNDERTAKER: Northam McCann | ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Shirley

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
(No. ..... St.)

File No. 32350
Registered No. 78

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Vivian Elizabeth Bergman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.)
Female	White	Child

6. DATE OF BIRTH: Dec. (Month) 19 (Day) 1917 (Year)

7. AGE: 2 Yrs. 10 Mos. 7 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: John Henry Bergman

11. BIRTHPLACE OF FATHER (State or Country): Neb.

12. MAIDEN NAME OF MOTHER: Verna Alice Holland

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Henry Bergman
(Address) Weiser Ida.

15. Filed 10/28/ 1920 — W R Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1920, to Oct 27 1920, that I last saw h[illegible] alive on Oct 27 1920, and that death occurred on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Enteric Colitis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. A. Shuey M. D.

10/28 1920 (Address) Weiser, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fullerest Cemetery	10-29 1920

20. UNDERTAKER	ADDRESS
Farnham & McCown	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington, Registration District No. 86

City of Weiser (No. ..... St.) Primary Registration District No. 1010

File No. 32287

Registered No. 99

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Arabelle Coldwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April (Month) 1 (Day) 1914 (Year)

7. AGE: 6 Yrs. 6 Mos. 30 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Alberta Canada

10. NAME OF FATHER: H. B. Coldwell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Louisa Woodruff.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H B Caldwell
(Address) Weiser Idaho

15. Filed Oct 31st 1920 Dr. R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 15 1920 to Oct 31 1920 that I last saw h[illegible] alive on Oct 26 1920 and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:

typhoid and pneumonia

Six weeks (Duration) ..... Yrs. 1 mos. 15 ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C C Cannon M. D.

Oct 13 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: Nov 2 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 33388
Registered No. 80

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delmer Preston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Wht	single

6. DATE OF BIRTH: Oct (Month) 1 (Day) 1918 (Year)

7. AGE: 2 Yrs. — Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Elmer Preston

11. BIRTHPLACE OF FATHER (State or Country) Oregon

12. MAIDEN NAME OF MOTHER Myrtle Jones

13. BIRTHPLACE OF MOTHER (State or Country) California

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Vere Adams
(Address) Weiser, Idaho.

15. Filed Nov. 3rd 1920 — W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24th 1920, to Nov 2nd 1920, that I last saw he alive on Nov 2nd 1920, and that death occurred on the date stated above, at 5 A. M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) Measles
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.
11/2 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerton Cemetery — DATE OF BURIAL: 11-3 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 1010

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32389

Registered No. 87

1. PLACE OF DEATH

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maryann Jensen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 27 (Day) 1842 (Year)

7. AGE: 78 Yrs. 9 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Lars Peterson

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frederick Jensen

(Address) .....

15. Filed 11/11/20 19.....

W R Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 9th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from several months - no record that I last saw h.. alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH was as follows:

Senility & Mitral Lesion of heart - Dropsy -

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G M Wakeham M. D.

11/10 19 20 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery — DATE OF BURIAL: 14/11 1920

20. UNDERTAKER: Northcraft & McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Waterhouse

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
(No. ..... St.)

File No. 32390
Registered No. 82

1. PLACE OF DEATH
County of Washington
City of Weiser
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Franklin Payton Laxson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write one word.)

6. DATE OF BIRTH: Oct (Month) 23 (Day) 1915 (Year)

7. AGE: 5 Yrs. — Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Jesse Payton Laxson

11. BIRTHPLACE OF FATHER (State or Country): Texas

12. MAIDEN NAME OF MOTHER: Luson Jane Baker

13. BIRTHPLACE OF MOTHER (State or Country): Ore.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J P Laxson
(Address) Weiser

15. Filed 11/11/20 19 W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 31 1920, to Nov 10 1920
that I last saw h[illegible] alive on Nov 10 1920
and that death occurred on the date stated above, at 11:35 A.M.
The CAUSE OF DEATH* was as follows:
Meningitis - cerebral

(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Typhoid fever
(Duration) ..... yrs. ..... mos. 12 ds.

(Signed) G M Waterhouse M. D.
11/11 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetry — DATE OF BURIAL: 11-12-1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Fennacy

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 32391
Registered No. 83

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geraldine Rodabaugh

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 31 (Day) 1918 (Year)

7. AGE: 2 Yrs. 0 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) Child

9. BIRTHPLACE (State or Country) Ida

10. NAME OF FATHER John Rodabaugh

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Ella Peterson

13. BIRTHPLACE OF MOTHER (State or Country) Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Rodabaugh
(Address) Weiser Ida

15. Filed 11/13/20 19 ..... W. R. Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 11 (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/11 19 20, to 11/12/20 19, that I last saw h.er alive on 11/12/20 19, and that death occurred on the date stated above, at 8.15 a.m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
following Measles
(Duration) Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) yrs. ..... mos. ..... ds.

(Signed) Ernest O. Fennacy M. D.
11/13/20 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery
DATE OF BURIAL: 11-14 1920

20. UNDERTAKER: Northam McCann
ADDRESS: Weiser

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Hamilton

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 2112

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32892

Registered No. 82

1. PLACE OF DEATH

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Achillia Ballenger Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: January (Month) 28th (Day) 1865 (Year)

7. AGE: 55 Yrs. ..... Mos. 9 ds. 22.

If LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Wm. Calvin Taylor

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: Mary Alice Baldwin.

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Alma Taylor

(Address) Weiser Idaho

15. Filed 11/21/20 19.....

W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20th 1920, to Nov 20th 1920 that I last saw h[illegible] alive on Nov 20th 1920, and that death occurred on the date stated above, at 1130 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. 8 hours ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

11/21 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weiser Cemetery — DATE OF BURIAL: 11/22 1920

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 86

Primary Registration District No. 2112

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32303

Registered No. 85

1. **PLACE OF DEATH**

County of Washington

City of Weiser

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Hazel V. Graham

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. **DATE OF BIRTH**

Aug (Month) 9 (Day) 1918 (Year)

7. **AGE**

2 Yrs. 3 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Ida

10. **NAME OF FATHER** Ellis Graham

11. **BIRTHPLACE OF FATHER** (State or Country) Ark.

12. **MAIDEN NAME OF MOTHER** Lilly V Hancock

13. **BIRTHPLACE OF MOTHER** (State or Country) Ark.

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Ellis Graham

(Address) Weiser Ida

15. Filed 11/25/ 1920

W. R. Hamilton
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**

Nov 23 (Month) (Day) 20 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Nov 13 19..., **to** Nov 21 19 20

that I last saw h. e/r **alive on** Nov 21 19 20

and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Fact Diphtheria Paralysis

(Duration) ..... yrs. ..... mos. 5 days

Contributory (Secondary) Diphtheria

(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) Jo Bonnichsen M. D.

Nov 25 20 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hillcrest Cemetery	11-25 19 20

20. **UNDERTAKER** Markham & McCann — **ADDRESS** Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 32294
Registered No. 86

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marvel E Graham
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 31 (Day) 1914 (Year)

7. AGE: 6 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida:

10. NAME OF FATHER: Ellis Graham

11. BIRTHPLACE OF FATHER (State or Country): Ark

12. MAIDEN NAME OF MOTHER: Lilly Hancock

13. BIRTHPLACE OF MOTHER (State or Country): Ark:

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B Gibson
(Address) Weiser Ida

15. Filed 11/30 1920 W. R. Hamilton — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 20 1920 to Nov 26 1920
that I last saw h[illegible] alive on Nov 26 1920
and that death occurred on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:

Diptheria

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
Nov 30 1920 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery
DATE OF BURIAL: 12-1 1920

20. UNDERTAKER: Northam McCann
ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 52390
Registered No.

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 622, State St., St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.

2. FULL NAME Frank Henton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Apr. 23 (Month) (Day) — 1854 (Year)

7. AGE: 66 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day, how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise, Idaho

15. Filed Dec 18 1920 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1920, to Dec 17 1920, that I last saw h-im alive on Dec 17 1920, and that death occurred on the date stated above, at 5:30 M.

The CAUSE OF DEATH* was as follows:
Cancer of Stomach & Bowels (Carcinomas)

(Duration) 1 Yrs. 3 mos. ds.
Contributory (Secondary) Uremia Poisoning
(Duration) 3 yrs. mos. ds.

(Signed) Geo. M. Mauk M. D.
12/17 1920. (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/19 1920.

20. UNDERTAKER: W. McBratney — ADDRESS: Boise, Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

— Copy —

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 295

Registration District No.
Primary Registration District No. 4004
(No. 622 State St. St.)

Registered No. 403

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Ada
City of Boise

2. FULL NAME Frank Henton

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Apr 23. 1854 (Month) (Day) (Year)

7. AGE: 66 Yrs. 7 Mos. 24 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stockman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Dont Know

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McBratney
(Address) Boise Idaho

15. Filed Dec 18 1920 R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 17 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4, 1920, to Dec. 17 1920 that I last saw him alive on Dec 17 1920 and that death occurred on the date stated above, at 8.30 A.M.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach & Bowels (Carcinoma)

(Duration) 1 Yrs. 3 mos. ds.

Contributory (Secondary) Ulceration of Stomach

(Duration) 3 yrs. mos. ds.

(Signed) Geo H. Handy M. D.

12/17 1920. (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL 19

20. UNDERTAKER: W McBratney — ADDRESS: Boise Idaho

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 2004
(No. Davis, Rauch, Fairview Ave)

File No. 32396
Registered No. 93

1. PLACE OF DEATH

County of Ada
City of Boise

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louie Wee Yo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: Yellow

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: (Month) (Day) 1864 (Year)

7. AGE: 56 Yrs. ... Mos. ... ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Gardner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): China

10. NAME OF FATHER: Dont Know.

11. BIRTHPLACE OF FATHER (State or Country): China

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): China

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Chong How
(Address):

15. Filed Dec 11 1920
D. H. Peate
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from Nov 15 1920, to Dec 4 1920 that I last saw him alive on Dec 1920 and that death occurred on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:
Was Doctor in attendance
Diabetis

(Duration) 1 Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) Chong How M. D.
19 ... (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hong Kong, China | DATE OF BURIAL: 12/10 1920

20. UNDERTAKER: Schreiber & Siedenfaden | ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Taylor.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 2004

State of Idaho
BOARD OF HEALTH,
Bureau of Vital Statistics

File No. 33399

Registered No. 95

1. **PLACE OF DEATH**

County of Ada

City of

(No. 1½ mi S.W. Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** John E. Griggs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White	Married (Write the word.)

6. DATE OF BIRTH: Jan 31 (Month) (Day) 1852 (Year)

7. AGE: 68 Yrs. 11 Mos. 13 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Cecil L Weeks
(Address)

15. Filed Dec 14 1920 — P. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 13 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th 1920, to Dec 9th 1920, that I last saw him alive on Dec 9th 1920, and that death occurred on the date stated above, at 1 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Taylor M. D.

Dec 14 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cemetery	Dec 15 1920.
20. UNDERTAKER: Summers & Stubbs.	ADDRESS: Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32400

Registered No. 94

1. PLACE OF DEATH

County of Ada

City of Near Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 8

Primary Registration District No. Ada 4

(No.) 3 Miles West of Boise

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Warren Culver

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct. 9. 1859 (Month) (Day) (Year)

7. AGE: 61 Yrs. 3 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin.

10. NAME OF FATHER: Walter Culver

11. BIRTHPLACE OF FATHER (State or Country): New York.

12. MAIDEN NAME OF MOTHER: Emily Cantens

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. H. Thompson

(Address) Boise Idaho

15. Filed Dec 14 1920 R. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 12 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1920, 15 m. before death to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Not known

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo Culver M. D.

Dec 14 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec. 16 1920

20. UNDERTAKER: Summers & Webb. — ADDRESS: Boise Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of this certificate.

1. PLACE OF DEATH

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Richter

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Jan (Month) 18 (Day) 1840 (Year)

7. AGE: 80 Yrs. 10 Mos. 29 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Boise Idaho
(Address) Owen Richter

15. Filed Dec 17 1920 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/1 1920 to 12/17 1920 that I last saw h[illegible] alive on 12/15 1920 and that death occurred on the date stated above, at 8 A M.
The CAUSE OF DEATH* was as follows:
Right Side Hemiplegia
(Duration) Yrs. mos. ds.
Contributory (Secondary) Arterio-Sclerosis
(Duration) yrs. mos. ds.
(Signed) [signature] M. D.
12/17 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 18 1920

20. UNDERTAKER: Summers & Cobb — ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32402

Registered No. 98

Registration District No. 8

Primary Registration District No. 2004

1. PLACE OF DEATH

County of Ada

City of Near Boise (No. Soldiers Home, St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Warren W. Robbins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White.	

6. DATE OF BIRTH (Month) (Day) 1846 (Year)

7. AGE 74 Yrs. ... Mos. ... ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veteran Civil War
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Unknown

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER (State or Country) Unknown

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clyde E. Summers
(Address) Boise Idaho

15. Filed Dec 20 1920 P. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1920 to Dec 19 1920 that I last saw him alive on Dec 19 1920 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Senility

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary) Asthenia Sclerosis

(Duration) ... yrs. ... mos. ... ds.

(Signed) Fred C Lumpke M. D.

12/20 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 21 1920

20. UNDERTAKER: Summers & Kirby — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. .....
File No. 32403
Registered No. .....

1. PLACE OF DEATH

County of Ada
City of Boise
(No. 1/2 Mile South Whitney School St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eugenia A. McEwen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: May 31 — 1853
(Month) (Day) (Year)

7. AGE: 67 Yrs. 6 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Louis Mo

10. NAME OF FATHER: James Ferguson

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Sarah DeMier

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm McE Bratney
(Address) Boise Idaho

15. Filed Dec 22 1920 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 20 — 1920
(Month) (Day) 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1920 to Dec 20 1920, that I last saw her alive on Nov 10 1920, and that death occurred on the date stated above, at 5 a M.

The CAUSE OF DEATH* was as follows: Dropsy & T Rheumatism

(Duration) 5 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. H. Hawley M. D.
12/22 19 20 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/22 19 20

20. UNDERTAKER: W McE Bratney — ADDRESS: Boise Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8

Primary Registration District No. 1004

File No. 32404

Registered No. 101

1. PLACE OF DEATH

County of Ada

City of

(No. 3 Miles West of Boise St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adelaide E. Wohlschlegel

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 23 (Day) 1901 (Year)

7. AGE: 19 Yrs. 2 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn

10. NAME OF FATHER: H. W. Wohlschlegel

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Florence Blanchard

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. J. S. Jenkins

(Address) Barber, Idaho.

15. Filed 12/20 1920

R. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1920 to Dec 28 1920, that I last saw her alive on Dec 28 1920, and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) Cardiac Exhaustion

(Duration) ..... yrs. ..... mos. 1 ds.

(Signed) F. N. Braxton M. D.

Dec 27 1920 (Address) Empire B. Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery

DATE OF BURIAL: Dec 31 1920

20. UNDERTAKER: Summers & Keeler

ADDRESS: Boise, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
CERTIFICATE NO.
Registrar's No. 32[illegible]

1. PLACE OF DEATH

County of Ada

Registration District No. 8

Primary Registration District No. 2004.

City of ..... (No. 4 miles west of Boise, St.)

File No. .....

Registered No. 102

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph N. Roberts.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word): Married.

6. DATE OF BIRTH: Apr 1 (Month) (Day) (Year)

7. AGE: 67 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: William Roberts

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Trebar.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Josephine H Roberts

(Address) Boise R.D.2.

15. Filed 12/31 1920 R H Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 28 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased from Dec. 29, 1920, to ..... 19....., that I last saw ~~him~~ alive on and Dec 29 1920, and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. E. Summers Coroner M. D.

12/29 1920. (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem. DATE OF BURIAL: Jan 2 1921

20. UNDERTAKER: Summers & Kirk. ADDRESS: Boise Idaho.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

32400

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

(No. St. Lukes Hospital St.)

File No.

Registered No. 389

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.)
M.	White	Single

6. DATE OF BIRTH Dec 1 (Month) – 1920 (Day) 1 (Year)

7. AGE — Yrs. — Mos. — ds.

IF LESS than 1 day how many 5 hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Isabel Clark.

13. BIRTHPLACE OF MOTHER (State or Country) Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isabel Clark.

(Address) Boise Idaho.

15. Filed Dec 4 1920. R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1920, to Dec 1 1920, that I last saw h alive on Nov 30 1920, and that death occurred on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:

Prematurity

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Dupation) yrs. mos. ds.

(Signed) Edward H Lewis M. D.

12/1 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Dec 1 1920

20. UNDERTAKER	ADDRESS
Summers & Cobb.	Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

J Springer

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 32407
Registered No. 3

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Homer M. Sackett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Feb. 15 1908 (Month) (Day) (Year)

7. AGE: 12 Yrs. 8 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho

10. NAME OF FATHER: Clarence C. Sackett

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: Bessie M. Barker

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs. B. E. Baker
(Address): Parma Ida R #3

15. Filed Dec 7 1920 R. H. Reed Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 3 1920, to Dec 4 1920
that I last saw h[illegible] alive on Dec 3 1920,
and that death occurred on the date stated above, at 7 a M.
The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Ruptured appendix
(Duration) ..... yrs. ..... mos. 4 ds.

(Signed) J D Springer M. D.
Dec 4 1920. (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL [redacted] Parma Ida | DATE OF BURIAL Dec 6 1920
20. UNDERTAKER Summers & Kirk | ADDRESS Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32408
Registered No.

Registration District No. V
Primary Registration District No. 1004

1. PLACE OF DEATH
County of Ada Co
City of Boise
(No. 1412 Washington Ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ann Beglan
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: 2 (Month) 3 (Day) 1840 (Year)

7. AGE: 80 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER: Kelly

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Matt Beglan
(Address) 1412 Washington Boise

15. Filed Dec 6 1920 R. H. Coats Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: DEC (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1920 to Dec. 3 1920 that I last saw h.e alive on Dec. 3 1920 and that death occurred on the date stated above, at 9P M.
The CAUSE OF DEATH* was as follows:
Fracture of neck

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Carl Hill, M. D.
12/4 1920 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fort Jones California
DATE OF BURIAL: Shipment 12/6 1920

20. UNDERTAKER: Schreiber & Sidenfaden
ADDRESS: Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32409

Registered No.

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 2

Primary Registration District No. 1004

(No. 615 W. Washington)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Miles Knapp

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Jan. 16 (Month) (Day) 1841 (Year)

7. AGE: 79 Yrs. 10 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Clergyman

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: Knapp

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Susan Mills

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ethel M Knapp

(Address) 615 Washington St.

15. Filed Mar 6 1920 D. H. Peate Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16th 19..., to Dec 4th 1920, that I last saw him alive on Dec 1st 1920, and that death occurred on the date stated above, at 11P. M.

The CAUSE OF DEATH* was as follows:

Causes of Stomach

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic indigestion, probably Gastric ulcer

..... (Duration) 40 yrs. — mos. ..... ds.

(Signed) J. M. Taylor M. D.

12/7 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 6 19 20

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

Stewart

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32410

Registered No.

Registration District No. 2

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise

(No. St. Lukes Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Chas Joel Rayl.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	White	Married

6. DATE OF BIRTH: March 30 (Month) (Day) 1894 (Year)

7. AGE: 26 Yrs. 8 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: J. N. Beacham.

11. BIRTHPLACE OF FATHER (State or Country): Illinois.

12. MAIDEN NAME OF MOTHER: Sarah E. Stewart

13. BIRTHPLACE OF MOTHER (State or Country): Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. A. Rayl
(Address) McLean Idaho

15. Filed Dec 8 1920 — R. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 6 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1920 to Dec 6 1920 that I last saw h..... alive on Dec 6 1920. and that death occurred on the date stated above, at 9:25 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Lobular Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James L. Stewart M. D.

(Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Dec 8 1920
20. UNDERTAKER	ADDRESS
Summers & Kebs.	Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2
Primary Registration District No. 1004
File No. 32411
Registered No. 379

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.
(No. 110 E. Bannock St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Iva Marie Thompson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 20 (Day) 1894 (Year)

7. AGE: 26 Yrs. 0 Mos. 16 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: Soren P. Jensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Nellie Wesner

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Glenn W. Thompson
(Address) Boise, Idaho R. 4.

15. Filed Dec 7 1920 P. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1920 to Dec 6 1920 that I last saw her alive on Dec 5 1920, and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:
Peritonitis and
general Septicaemia

(Duration) ..... Yrs. ..... mos. 24 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. Earl Hill M. D.
12/7/20, 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetary — DATE OF BURIAL: Dec 7 1920
20. UNDERTAKER: Summers & Tate — ADDRESS: Boise Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32412

1. PLACE OF DEATH

County of Ada

City of Boise.

Registration District No. 2

Primary Registration District No. 1004

(No. St Lukes Hospital St.)

Registered No. 7

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Charles W. Eaton

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	W.	Write the word — Widower

6. DATE OF BIRTH: July 27 (Month) (Day) 1 (Year)

7. AGE: 63 Yrs. 4 Mos. 11 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Stephen Eaton

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred Eaton

(Address) Wendell.

15. Filed Dec 11 1920 — R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 8 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May — 1920 to Dec 8 1920 that I last saw h..... alive on Dec 7 1920 and that death occurred on the date stated above, at 7 P.M.

The ~~CAUSE~~ OF DEATH* was as follows:

Conjestion

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Jno. M. Olmsted M. D.

19 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Dec 11 1920

20. UNDERTAKER: Summers & Webb. — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

Taylor.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2

Primary Registration District No. 1004

File No. 32412

Registered No. 3277

1. PLACE OF DEATH

County of Ada

City of Boise,

(No. St Lukes Hospital, St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phillippa L. Martyn.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married

6. DATE OF BIRTH

Aug (Month) 24 (Day) 1886 (Year)

7. AGE

34 Yrs. 3 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) England.

10. NAME OF FATHER William Wannacott

11. BIRTHPLACE OF FATHER (State or Country) England.

12. MAIDEN NAME OF MOTHER Sarah Rodda.

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Edward Martyn

(Address) .....

15. Filed Dec 1/13 1920 R. H. Pratt Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7th 1920, to Dec 10th 1920, that I last saw h[illegible] alive on Dec 10th 1920, and that death occurred on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Bronchitis Streptococcus infection Edema Uremia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) following measles

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Taylor M. D.

Dec 11th 1920 (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 4 days

Where was disease contracted if not at place of death? at residence

Former or usual residence 1209 No 13th St.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Morris Hill Cem	Dec 13 1920.
20. UNDERTAKER	ADDRESS
Summers & Hebb.	Boise Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32414
Registered No. 378

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1004
(No. 321 W. Bannock St.)

2. FULL NAME Ellen L Bush

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: March 13 (Month) (Day) 1848 (Year)

7. AGE: 72 Yrs. 5 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Western Star, Ohio

10. NAME OF FATHER: Milton Kelley

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Lois Humphrey

13. BIRTHPLACE OF MOTHER (State or Country): Goshen Conn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) for Treasurer
(Address) Boise Ida

15. Filed Dec 12 1920 — R H Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 11 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 6 1920, to Dec. 11 1920, that I last saw her alive on Dec 10 1920, and that death occurred on the date stated above, at 7 1 M.

The CAUSE OF DEATH* was as follows:
Dilatation of heart

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Goitre
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J S Springer M. D.
Dec 11 1920 (Address) Boise Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery — DATE OF BURIAL: 12/12 1920

20. UNDERTAKER: Schreiber & Liddycoat — ADDRESS: Boise

Dr. Springer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32415

Registered No. 899

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 917 E. Bannock St.)

Registration District No. 2

Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lulu Keyser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	White.	Married

6. DATE OF BIRTH June 12 1876
(Month) (Day) (Year)

7. AGE 44 Yrs. 6 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Emmon Kingsbury

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Mary Kimberly

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) S R Keyser

(Address) 917 E Bannock.

15. Filed Mch 13 1920 R H Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 12 — 12 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920, to Dec 12 1920
that I last saw her alive on Dec 12 1920
and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Influenza - 1 year ago.

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. H. Talman M. D.

12/13 1920 (Address) Boise, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Morris Hill Cemetery | DATE OF BURIAL Dec 14 1920

20. UNDERTAKER Summers & Krebs | ADDRESS Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1004
File No. 32416
Registered No. 400

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 323 Hayes St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Marie Thompson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June 13 1920 (Month) (Day) (Year)

7. AGE: 0 Yrs. 6 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Glenn W. Thompson

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Iva Marie Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W H Thompson
(Address) Boise Ida

15. Filed Dec 17 1920 R H Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 15 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Dec 15 1920, that I last saw h. alive on Dec 15 1920 and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Gastro-Enteritis
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H B Smith M. D.
12/15 1920 (Address) Boise, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 16 1920
20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 8

Primary Registration District No. 1004

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32417

Registered No. 402

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 1414 E. Bannock St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Belle M. Bacon.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Married

6. DATE OF BIRTH: Mar. (Month) 16 (Day) 1861 (Year)

7. AGE: 59 Yrs. 9 Mos. 0 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: James. Crow.

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Charlotte Hickock

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M B Bacon

(Address) 1414 E Bannock

15. Filed Mar 17 1920 — P. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4 1920, to Dec. 16 1920, that I last saw h-- alive on Dec. 15 1920, and that death occurred on the date stated above, at 7 A M.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation and lack of tone, with final Rupture

(Duration) Yrs. 6 mos. ds.

Contributory (Secondary) Goiter

(Duration) yrs. mos. ds.

(Signed) R. S. Gregory M. D.

19 (Address) 1107 N. 10th St.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 18 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8
Primary Registration District No. 8004
File No. 32418
Registered No. 122

1. PLACE OF DEATH
County of Ada
City of Boise.
(No. Soldiers Home St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Wilson.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widower.

6. DATE OF BIRTH: Dec — 1833
(Month) (Day) (Year)

7. AGE: 87 Yrs. — Mos. — ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Soldier.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa. Pittsburgh.

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mat. G. Berridge
(Address)

15. Filed 12/22 1920 R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 22 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Dec 22 1920
that I last saw him alive on Dec 21 1920
and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:

Senility

.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary)
.....(Duration) .....yrs. .....mos. .....ds.

(Signed) Otto Saltzer M. D.
12/22 1920 (Address) Owsley Bldg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Dec 23 1920

20. UNDERTAKER: Summers & Kibbe. — ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 32419
Registered No. 404

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 410 State St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pedra Bermensolo

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: March 15 (Month) (Day) 1886 (Year)

7. AGE: 34 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housekeeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Spain

10. NAME OF FATHER: Domingo Yturrieta

11. BIRTHPLACE OF FATHER (State or Country): Yurreta

12. MAIDEN NAME OF MOTHER: Fransisca Uzueta

13. BIRTHPLACE OF MOTHER (State or Country): Yurreta

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Antonio Bermisolo
(Address):

15. Filed Diembre 8 1920. P. H. Pratt, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 18th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1920, to Dec 18 1920, that I last saw he alive on Dec 17 1920, and that death occurred on the date stated above, at 7:30 A.M.
The CAUSE OF DEATH* was as follows:
Chronic myocarditis
Chronic Endocarditis
(Duration) 10 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. Earl Hall M. D.
12/18 1920, (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 18 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Jordan Valley, Idaho

19. PLACE OF BURIAL OR REMOVAL: Jordan Valley Ore. DATE OF BURIAL: 12/20 1920

20. UNDERTAKER: Schreiber & Sidenfaden ADDRESS: Boise Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

J. H. Hall

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32420

Registered No. 407

Registration District No. 4

Primary Registration District No. 1004

1. PLACE OF DEATH

County of Ada

City of Boise

(No. 529 So 16th St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry W. Paris

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 18th (Day) 1920 (Year)

7. AGE: ——— Yrs. ——— Mos. ——— ds.

IF LESS than 1 day how many 3 hrs. or ——— min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise, Idaho

10. NAME OF FATHER: Isaac Paris

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Grace Greenwell

13. BIRTHPLACE OF MOTHER (State or Country): Kans.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) I. Paris

(Address) Boise

15. Filed Dec 20 1920 R. H. Gray Local Registrar

Gregory.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 18th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18th 1920, to Dec. 18th 1920, that I last saw him alive on ——— 19 20 and that death occurred on the date stated above, at ——— M.

The CAUSE OF DEATH* was as follows:

Premature birth

——— (Duration) ——— Yrs. ——— mos. ——— ds.

Contributory (Secondary)

——— (Duration) ——— yrs. ——— mos. ——— ds.

(Signed) R. S. Gregory M. D.

19 ——— (Address) 1107 N. 8th

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ——— yrs. ——— mos. ——— days. In the State ——— yrs. ——— mos. ——— days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: 12/21 1920

20. UNDERTAKER: Schreiber & Siebenfaden — ADDRESS: Boise, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32421
Registered No. 418

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5

Primary Registration District No. 1004

(No. 111 S. W. Washington St.)

2. FULL NAME John Hannah

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1855 (Year)

7. AGE: 65 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Unknown

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Clyde E. Summers

(Address) 906 Bannock St. Boise Ida

15. Filed 12/22 1920 R. H. Pratt, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended~~ saw deceased ~~from~~ Dec 21 1920, to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at unknown M.

The CAUSE OF DEATH* was as follows: Suicide. Gun Shot Wound

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner M. D.

12/22 1920 (Address) Boise Idaho of Ada County

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 23 1920

20. UNDERTAKER: Summers & Kribs — ADDRESS: Boise Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Ada

City of Boise

(No. ..... St.)

Registration District No. 7

Primary Registration District No. 1004

File No. 32422

Registered No. 409

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucile Crane

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH

Dec (Month) 25 (Day) 1920 (Year)

7. AGE

..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 8 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ——

(b) General nature of industry, business or establishment in which employed (or employer) ——

9. BIRTHPLACE (State or Country) Boise Idaho

10. NAME OF FATHER Frank Crane

11. BIRTHPLACE OF FATHER (State or Country) South Dakota

12. MAIDEN NAME OF MOTHER Vida Vickers

13. BIRTHPLACE OF MOTHER (State or Country) Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Nampa Idaho

15. Filed Dec 27 1920 R. H. Poole Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1920 to Dec 25 1920 that I last saw h..... alive on Dec 25 1920, and that death occurred on the date stated above, at 3 30 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth

.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Lucile Crane M. D.

Dec 27 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Idaho	Dec 27 1920

20. UNDERTAKER	ADDRESS
W. B. Mater	Meridian Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1004
File No. 32423
Registered No. 410

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 110 E. Bannock St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Orpha Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 17 (Day) 1885 (Year)

7. AGE: 35 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: Levy Cox

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Jane Hucker

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Griffith Jones
(Address) 1615 Main St. Boise Ida

15. Filed Dec 26 1920 A. H. Peale
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1920, to Dec 24 1920
that I last saw h[illegible] alive on Dec 23 1920
and that death occurred on the date stated above, at 1.30 P. M.
The CAUSE OF DEATH* was as follows:
Killed by fall from 2d Story window

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) [illegible]
..... (Duration) ..... yrs. ..... mos. 4 ds.
(Signed) M Allen Conaway M. D.
1920 (Address) Boise

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicid[illegible]

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 26 1920
20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 32424
Registered No. 413

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 902 Main St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Thomas Roberts

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH
April 19 1899
(Month) (Day) (Year)

7. AGE
21 Yrs. 7 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Real Estate
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Nebraska

10. NAME OF FATHER Claude H. Roberts

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Elizabeth Mabesky

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Claude H. Roberts
(Address) Broadway & Park Sts

15.
Filed 12/31/20 19.....
T. H. Pratt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 30 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, ~~That~~ I ~~attended~~ deceased ~~from~~
Dec 30 1920 to ..... 19.....
that I last saw h~~im~~ alive on Dec 30 1920,
and that death occurred on the date stated above, at 3 0 M.

The CAUSE OF DEATH* was as follows:
Accidently killed by
bullet shot in the head
by .22 Caliber Revolver
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Clyde E. Summers Coroner M. D.
12/31 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery
DATE OF BURIAL: Jan 1 1921

20. UNDERTAKER: Summers & Krebs
ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 32425
Registered No. 472

1. PLACE OF DEATH
County of Ada
City of Boise
(No. 512 N. 12 St. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Minnie E. Brown
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 29 (Day) 1845 (Year)

7. AGE: 75 Yrs. 6 Mos. 28 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Unknown Bowman

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. W. Treadwell
(Address) 1114 W. 13th — Boise

15. Filed Dec 31 1920
R. H. Pratt
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 1 1919, to Dec 27 1920, that I last saw her alive on Oct 10 1920, and that death occurred on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis

(Duration) 4 Yrs. mos. ds.
Contributory (Secondary) Angina Pectoris
(Duration) yrs. mos. 15 min. ds.

(Signed) F. N. Braptan M. D.
Dec 29 1920 (Address) Empire B. Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Masonic Cemetery
DATE OF BURIAL: Jan 1 1921

20. UNDERTAKER: Summers & Kirk
ADDRESS: Boise Idaho

FORM V. S. No. 1-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32426
Registered No. 411

1. PLACE OF DEATH
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1004
(No. 410 State St.)

2. FULL NAME Zacarias Echanove

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)
7. AGE: 32 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheepherder
(b) General nature of industry, business or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Spain
10. NAME OF FATHER: Timoteo Echanove
11. BIRTHPLACE OF FATHER (State or Country): Spain
12. MAIDEN NAME OF MOTHER: Eneteria Amantegui
13. BIRTHPLACE OF MOTHER (State or Country): Spain
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jacinto Echanove
(Address) Boise Ida.
15. Filed Dec 29 1920 A. H. Pratt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from May 1 1920, to Dec 27 1920, that I last saw him alive on Dec 27 1920, and that death occurred on the date stated above, at 3. P. M.
The CAUSE OF DEATH* was as follows:
Intravenous of spine
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Geo Cahill M. D.
..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Boise Idaho

19. PLACE OF BURIAL OR REMOVAL: St Johns Cemetery — DATE OF BURIAL: 12/29 1920
20. UNDERTAKER: Schreiber & Sidenfaden — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

32427

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32429
Registered No. 414

1. PLACE OF DEATH

County of Ada

City of Boise

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1004

(No. 1419 Warm Springs Ave. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth L. Shirley

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 25 (Day) 1848 (Year)

7. AGE: 72 Yrs. 11 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Coon.

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jno. N. Cardwell

(Address) 1419 Warm Springs Ave

15. Filed 12/31 1920

R. K. Groth
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1920, to Dec 28 1920 that I last saw h..... alive on Dec 28 1920, and that death occurred on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) James L. Hamond M. D.

12/29 1920 (Address) Boise Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec 31 1920

20. UNDERTAKER: Summers & Tate — ADDRESS: Boise Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32428
Registered No. 415

1. PLACE OF DEATH
County of Ada
City of Boise,
(No. 410 W State, St.)
Registration District No. 7
Primary Registration District No. 1004

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Murphy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 30 (Month) (Day) 1920 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boise Idaho.

10. NAME OF FATHER: C E. Murphy

11. BIRTHPLACE OF FATHER (State or Country): Mich.

12. MAIDEN NAME OF MOTHER: Lorena Burton

13. BIRTHPLACE OF MOTHER (State or Country): U. S.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. E. Murphy
(Address) 503 Ash St.

15. Filed 12/31/ 1920
Local Registrar R. H. Coall

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....,
that I last saw h.... alive on ....19....,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Premature
5 hrs
(Duration) ....Yrs....mos....ds.
Contributory (Secondary)
(Duration) ....yrs....mos....ds.

(Signed) C. V. Gennaro M. D.
Dec 31 1920 (Address) Boise Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cemetery — DATE OF BURIAL: Dec. 31 1920

20. UNDERTAKER: Summers & Krebs — ADDRESS: Boise Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32429

Registered No.

1. PLACE OF DEATH

County of Ada

City of Eagle

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 9

Primary Registration District No.

(No. ....., ... St.)

2. FULL NAME Hellick Tibbam

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH June (Month) 17th (Day) 1852 (Year)

7. AGE 68 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Norway

10. NAME OF FATHER L. K. Tibbam

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Kari Kriele

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. H. Tibbam

(Address) Eagle, Ida.

15. Filed Dec. 16 1920 Frederic K. Lewis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th 1920, to Dec. 14 1920, that I last saw h.— alive on Dec 14 1920, and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Apoplexy

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Bright's Disease Arteriosclerosis

— (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frederic K. Lewis M. D.

Dec 16 1920 (Address) Eagle, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise, Idaho	19.....

20. UNDERTAKER	ADDRESS
McBratney	Boise Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 2161

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32430
Registered No. 3463

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No.) St Anthony Hospital (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dr. J. W. Cahill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: 1871 (Month) 1 (Day) (Year)

7. AGE: Exact date unknown
49 Yrs. Mos. ds.
If LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Veterinary Surgeon
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Cahill

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. J. Mooney
(Address) Pocatello Idaho

15. Filed Dec 1 1920. J. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1920, to Nov 28 1920, that I last saw him alive on Nov 28 1920, and that death occurred on the date stated above, at 4:15 M.

The CAUSE OF DEATH* was as follows:
Decompensation of heart
Myocarditis
(Duration) Yrs. 2 mos. ds.
Contributory (Secondary) Chronic interstitial
nephritis (Duration) 5 yrs. mos. ds.

(Signed) Ben Newton M. D.
Dec 1 1920 (Address) Kamberly Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Dec 3 1920

20. UNDERTAKER: Schumacher Bros — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32431

Registered No. 3464

Registration District No. 28

Primary Registration District No. 2161

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. 1 Pershing St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Linton Pratt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 26 (Day) 1855 (Year)

7. AGE: 65 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Isaac Pratt

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Helen Rooke

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Franklin Wells

(Address) Mt Cammon

15. Filed 1/2 19 26

J. H. Simms
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December (Month) 1 (Day) 1920 (Year)

I HEREBY CERTIFY, that attended deceased from Nov 16 1920 to Nov 30 1920

that I last saw h[illegible] alive on Nov 30 1920

and that death occurred on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Duration) Yrs. 6 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

1920 (Address) Mt Cammon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dillon Kansas — DATE OF BURIAL: Dec 19 20

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32432
Registered No. 3461

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2461
(No. 837 So Main St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Burma Linn Cooper

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single
6. DATE OF BIRTH: Aug (Month) 8 (Day) 1920 (Year)
7. AGE: 2 Yrs. 28 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Burley Ida
10. NAME OF FATHER: O. N. Cooper
11. BIRTHPLACE OF FATHER (State or Country): Oakley Ida
12. MAIDEN NAME OF MOTHER: Ova Smith
13. BIRTHPLACE OF MOTHER (State or Country): Authony Ida
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O. N. Cooper
(Address) Pocatello Ida
15. Filed 12/6 1920 J. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 5 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1920, to Dec 5 1920 that I last saw h[illegible] alive on Dec 5 1920 and that death occurred on the date stated above, at 9-30 P.M.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia - Bilateral

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Sprague M. D.
12/6 1920 (Address) Pocatello Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida | DATE OF BURIAL: 12/6 1920
20. UNDERTAKER: P. L. Parker ADDRESS Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32433
Registered No. 3466

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28
Primary Registration District No. 2161
(No. 453 S. Johnson St.)

2. FULL NAME Mrs. S. J. Roberts

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: April (Month) 11 (Day) 1856 (Year)

7. AGE: 64 Yrs. 6 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Huntsville Alabama

10. NAME OF FATHER: Logan Gunn

11. BIRTHPLACE OF FATHER (State or Country): /

12. MAIDEN NAME OF MOTHER: Martha J. Gunn

13. BIRTHPLACE OF MOTHER (State or Country): /

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) S. J. Roberts
(Address) Pocatello

15.
Filed 12/6 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 5th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1919, to Dec 5th 1920
that I last saw her alive on Dec 5 1920
and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(Duration) Yrs. 8 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

12/6 1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cemetery | DATE OF BURIAL: 12/7 1920

20. UNDERTAKER: P. T. Tracey | ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 32434
Registered No. 3417

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME David James Rose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: November 23 (Month) (Day) 1887 (Year)

7. AGE: 33 Yrs. – Mos. 11 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Chief clerk to Engineer
(b) General nature of industry, business or establishment in which employed (or employer): Bridge & Bldg. O.S.L.

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Rose

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs David J. Rose
(Address) Pocatello

15. Filed 12/7 1920 — J. Thomas — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 4 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13 1920 to Dec 4. 1920, that I last saw h[illegible] alive on Dec 4 1920, and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:

Encephalitis

(Duration) ____ Yrs. ____ mos. 1 ds.
Contributory (Secondary): Acute Sup. Otitis Media
(Duration) ____ yrs. ____ mos. 20 ds.

(Signed) [signature] M. D.
12/8 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pocatello Cem. | DATE OF BURIAL: Dec 8 1920

20. UNDERTAKER: Schumacher & Hall | ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 961
File No. 32435
Registered No. 3468

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. 1009 So Third St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clara Hansen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Child (Write the word.)

6. DATE OF BIRTH March 5 1916 (Month) (Day) (Year)

7. AGE 4 Yrs. 9 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business or establishment in which employed (or employer): at Home

9. BIRTHPLACE (State or Country) Blackfoot Ida.

10. NAME OF FATHER J Nicholas Hansen

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Pauline Pedersen

13. BIRTHPLACE OF MOTHER (State or Country) Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J Nicholas Hansen

(Address) 1009 So Third

15. Filed 12/10 1920 J. H. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 9 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 1920, to Dec 9 1920, that I last saw h[illegible] alive on Dec 9 1920, and that death occurred on the date stated above, at 9:30 M.

The CAUSE OF DEATH* was as follows:

acute diffuse nephritis

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) Scarlet Fever

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) D C Ray M. D.

12/10 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Mountain View Cem — **DATE OF BURIAL** Dec 11 1920

20. UNDERTAKER Schumacher & Hall — **ADDRESS** Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 1 6161
File No. 32436
Registered No. 3469

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. 434 West Wieth St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Paris Williams
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 15 (Day) 1920 (Year)

7. AGE: — Yrs. 2 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pocatello, Ida

10. NAME OF FATHER: Aubrey Williams

11. BIRTHPLACE OF FATHER (State or Country): Rhode Island

12. MAIDEN NAME OF MOTHER: Bessie Ellison

13. BIRTHPLACE OF MOTHER (State or Country): Oklahomma

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bessie E. Williams
(Address) 434 W. Wieth st

15. Filed Dec 10 1920 J R Gowns
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1920, to Dec 9 1920, that I last saw ~~was~~ alive on Dec 9 1920, and that death occurred on the date stated above, at 10 P. M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Premature birth
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. W. Brothers M. D.
Dec 10 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt View
DATE OF BURIAL: Dec 11 1920

20. UNDERTAKER: H. L. McHaw
ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2164
File No. 3237
Registered No. 3470

1. PLACE OF DEATH
County of Bannock
City of Pocatello
If death occurs away from usual residence, give facts called for under special information.

(No. Emerson & Fort St. St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nora Irene Fullen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: July 22 (Month) (Day) 1881 (Year)

7. AGE: 39 Yrs. 4 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): East Cache

10. NAME OF FATHER: David D. Foster

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Nora Fullen
(Address) Pocatello

15. Filed 12/13 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 12 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1920 to Dec 12 1920
that I last saw her alive on Dec 12 1920,
and that death occurred on the date stated above, at 5 P. M.
The CAUSE OF DEATH* was as follows:

Tabes dorsalis
Locomotor ataxia
(Duration) 1 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. J. Post M. D.
12/12 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Cemetery — DATE OF BURIAL: 12/15 1920

20. UNDERTAKER: H. D. Walker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 2161
File No. 32438
Registered No. 3471

1. PLACE OF DEATH
County of Bannock
City of Tyhee
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant K. Morimoto

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Japanese

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 14 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Tyhee Idaho

10. NAME OF FATHER: K. Morimoto

11. BIRTHPLACE OF FATHER (State or Country): Japan.

12. MAIDEN NAME OF MOTHER: Katsue Uno

13. BIRTHPLACE OF MOTHER (State or Country): Japan.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) K. Morimoto
(Address) Tyhee Ida.

15. Filed 12/17 1920 J. P. Young. Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1920, to Dec 16 1920, that I last saw him alive on Dec 16 1920 and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
caused by Phillosophy of Umbilical
birth
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Very low vitality and inability to react to environment
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carl W. Clark M. D.
12/17 1920 (Address) Pocatello Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Japanese Cemetery — DATE OF BURIAL: 12/17 1920

20. UNDERTAKER: W. W. Baker — ADDRESS: Pocatello

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 28
Primary Registration District No. 216
File No. 32410
Registered No. 3473

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. O.S.L.R.R. Yards St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Arnold Blaser

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: November 22 (Month) (Day) 1874 (Year)

7. AGE: 46 Yrs. — Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Foreman Section
(b) General nature of industry, business or establishment in which employed (or employer): O.S.L. R.R.

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: Fredrick Blaser

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Elizabeth Larch

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr Gus Blaser
(Address) Minidoka

15. Filed 12/17 1920 J.P. Young Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 15 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Accidentally killed by locomotive engine (Decapitated)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) S D Seymour Coroner M. D.
12-17-1920 (Address) Pocatello Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelier Ida	Dec 16 1920
20. UNDERTAKER	ADDRESS
Schumacher Hall	Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 241
File No. 32412
Registered No. 3475

1. PLACE OF DEATH
County of Bannock
City of Pocatello
(No. General Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lena June Meyers.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March (Month) 31 (Day) 1917 (Year)

7. AGE: 2 Yrs. 8 Mos. 20 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer): None.

9. BIRTHPLACE (State or Country): Crystal.

10. NAME OF FATHER: J. H. Meyers.

11. BIRTHPLACE OF FATHER (State or Country): Providence Utah.

12. MAIDEN NAME OF MOTHER: Mabel Clarissa Butterfield

13. BIRTHPLACE OF MOTHER (State or Country): Lava Hot Springs Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. J. H. Meyers.
(Address) Crystal Ida. Powers Co.

15. Filed 12/21 1920 ... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 21 (Month) (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/14 1920, to 12-21 1920; that I last saw her alive on 12/21 1920, and that death occurred on the date stated above, at 3 9 M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia

(Duration) ... Yrs. ... mos. 8 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) ... M. D.
12/21 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence: Crystal Ida.

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Crystal Ida. DATE OF BURIAL: Dec. 23 1920.

20. UNDERTAKER: H. L. McSan. ADDRESS: Pocatello Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Lena June Meyers

now lying buried in Crystal Cemetery, in the City or Town of Crystal

County of Power State of Idaho, who died on the 21 day of December, 1921; Aged ____ years ____ months

____ days, the cause of death being Lobar Pneumonia and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

J. R. Young, M.D. attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private
private or railway conveyance

to Mt. View Cemetery in the City or Town of Pocatello County of Bannock

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Power it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 20th day of May, A.D. 19 77.

Permit issued to:
Manning Funeral Chapel
510 North Twelfth Ave.
Pocatello, Idaho 83201

Janet M. Wick
by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of ____ State of Idaho, this ____ day of ____, 19__.

Health Officer

FORM BH 56-019

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 28

Primary Registration District No. 216

(No. Lynn Bros Hospital St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32444

Registered No. 8477

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Norton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: November 23 1864 (Month) (Day) (Year)

7. AGE: 56 Yrs. 1 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: Edward Williams

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Margaret Phillips

13. BIRTHPLACE OF MOTHER (State or Country): Wales.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Mason

(Address) Lava Hot Springs.

15. Filed 12/27 1920 J. W. Howard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 26 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1920 to Dec 26th 1920 that I last saw h.r alive on Dec 26th 1920 and that death occurred on the date stated above, at 5A M.

The CAUSE OF DEATH* was as follows:

cancer of the uterus

(Duration) Yrs. 6 mos. 2 ds.

Contributory (Secondary) operation

(Duration) yrs. mos. 4 ds.

(Signed) W. Lynn M. D.

Dec 27 1920 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death Lynn Bros. Hosp. yrs. mos. days. In the State yrs. mos. 11 days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lava Hot Springs — DATE OF BURIAL: Dec 29 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32475
Registered No. 3478

1. PLACE OF DEATH

County of Bannock
City of Pocatello
(No. Perkins Rooming House St.)

Registration District No. 28
Primary Registration District No. 8161

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Gonsalez

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: Mexican

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: about March 1 1890
(Month) (Day) (Year)

7. AGE: 30 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min ?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Gonsalez

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Joe McKenna
(Address) Dale Rooming House

15. Filed 12/28 1920 J. P. Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 26 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-23 1920, to 19..., that I last saw h... alive on 19..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:

Alcoholic Poisoning

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) S. D. Ferguson Coroner
12-28 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ...yrs. ...mos. ...days. In the State ...yrs. ...mos. ...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Dec 28 1920

20. UNDERTAKER: Schumacher Bros — ADDRESS: City Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32446

Registered No. 3481

1. PLACE OF DEATH

County of Bannock

City of Pocatello

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 28

Primary Registration District No. 2161

(No. St Anthony Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Luella J. Raymond.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: September 14 1840 (Month) (Day) (Year)

7. AGE: 60 Yrs. 3 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Salt Lake City Ut.

10. NAME OF FATHER: Parmeno Jackman

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Phoeb L Merill

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A Raymond
(Address) McCammon

15. Filed 1/3/21 1920 J H Young Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 30 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1920, to Dec 30 1920, that I last saw her alive on Dec 30 1920 and that death occurred on the date stated above, at 1 00 P.M.

The CAUSE OF DEATH* was as follows: Fracture upper third right femur.

(Duration) ..... Yrs. 2 mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Brotherton M. D.

Dec 31 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
McCammon Ida	1-3 1921
20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Dr. Brothers

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 28

City of Pocatello — Primary Registration District No. 246 — File No. 32447

(No. General Hospital St.) — Registered No. 848

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Nora M. Buckendorf

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: Nov 9th 1883 (Month) (Day) (Year)

7. AGE: 37 Yrs. 1 Mos. 21 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill—

10. NAME OF FATHER: Geo. Wininger

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James H. Buckendorf
(Address) Pocatello Ida

15. Filed 1/30 1921 — J P Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 30th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1920, to Dec 29 1920, that I last saw h[illegible] alive on Dec 29 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:-
Mitral regurgitation
with broken compensation.
Myocarditis.
(Duration) 1 mos.

Contributory (Secondary)
(Duration)

(Signed) W. W. Brothers M. D.
Dec 31 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mountain View — DATE OF BURIAL: Dec 31 1920

20. UNDERTAKER: Schumacher Hay — ADDRESS: City

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32448

Registered No. 3479

1. PLACE OF DEATH

County of Bannock

City of Pocatello

(No. 1033 West Fremont St.)

Registration District No. 28

Primary Registration District No. 216

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth J Palmer

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: January 6 1832 (Month) (Day) (Year)

7. AGE: 88 Yrs. 11 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Foxall

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Jenkins

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R A Palmer

(Address) Pocatello Ida

15. Filed 12/29 1920

J P Young
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 29 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1920, to Dec 29 1920, that I last saw h..er.. alive on Dec 27 1920, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Cystitis, followed by
Nephritis of bladder and
Bowels, and obstipation.

(Duration) Yrs. 1 mos. 5 ds.

Contributory (Secondary) Old age, and Senile debility and loss of mem

(Duration) 1 yrs. mos. ds.

(Signed) Carl W. Clark M. D.

Dec 29 1920 (Address) Pocatello Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City, Utah — DATE OF BURIAL: 12/31 1920

20. UNDERTAKER: Schumacher & Hall — ADDRESS: Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 83

Primary Registration District No.

File No. 32449

County of Canyon

City of Caldwell (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alice Walding

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: 2 (Month) 12 (Day) 1920 (Year)

7. AGE: ..... yrs. 8 mos. 26 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Heber Walding

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Julia Bybee

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Heber Walding

(Address) Downey Idaho

15. Filed Nov 10 1920 L. J. Hartzipure
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 25, 1920, to Nov 8 1920 that I last saw he alive on Nov. 7, 1920 and that death occurred on the date stated above, at 2 p.m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — yrs. — mos. 13 ds.

Contributory (Secondary) None

(Duration) — yrs. — mos. — ds.

(Signed) L. J. Hartzipure M. D.

11-10-1920 (Address) Caldwell, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: Nov 10 1920

20. UNDERTAKER: C E Layton — ADDRESS: Downey

GYM3 - YORK CO., PTRS. & BDRS. 19760

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32450

Registered No.

1. PLACE OF DEATH

County of Bannock

City of Mawney

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 83

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Clinton Reese Hartzgen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	white	single (Write the word.)

6. DATE OF BIRTH July (Month) 9 (Day) 1910 (Year)

7. AGE 10 Yrs. 4 Mos. 9 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Mawney, Idaho

10. NAME OF FATHER Neils J. Hartzgen

11. BIRTHPLACE OF FATHER (State or Country) Hyrum, Utah.

12. MAIDEN NAME OF MOTHER Suetta Brown

13. BIRTHPLACE OF MOTHER Nebraska (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Neils J. Hartzgen,

(Address) Mawney, Idaho

15. Filed 11-5-1920 H. H. Hartzgen Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH October (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec., 7, 1919, to Oct., 31, 1920, that I last saw him alive on Oct., 31, 1920, and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus.

(Duration) Yrs. mos. ds.

Contributory (Secondary) —

(Duration) yrs. mos. ds.

(Signed) H. H. Hartzgen M. D.

11-3-1920 (Address) Mawney, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Mawney, Idaho	11-3-1920
20. UNDERTAKER	**ADDRESS**
C. E. Grayton	Mawney.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32451
Registered No.

1. PLACE OF DEATH
County of Ben Lake
City of St Charles
(No. ....., ... St.)
Registration District No. 53
Primary Registration District No. 2132
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Andrew Jacobson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec. (Month) 1 (Day) 1850 (Year)

7. AGE: 69 Yrs. 11 Mos. 20 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden.

10. NAME OF FATHER: Morton Jacobson

11. BIRTHPLACE OF FATHER (State or Country): Sweden.

12. MAIDEN NAME OF MOTHER: Annie Nilson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Johnnie Engemire
(Address)

15. Filed 12/10/20 19.... L. P. Button Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Had no to Doctor 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 3:20 A.M.

The CAUSE OF DEATH* was as follows:
Old Age.

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) X Johnnie Engemire M. D.
Nov 21 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Charles — DATE OF BURIAL: Nov 23 1920

20. UNDERTAKER: Bishop Hunt. — ADDRESS: St Charles

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 53
Primary Registration District No. 2136
File No. 32452
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs Irene Miller

If death occurred in hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: May 22 1843 (Month) (Day) (Year)

7. AGE: 77 Yrs. 4 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Huntingdon Co Pennsylvania

10. NAME OF FATHER: John Snoop

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Amy Chilcott

13. BIRTHPLACE OF MOTHER (State or Country): Maryland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A M Miller
(Address) Fairfield Idaho

15. Filed 12-1-1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 12 1920, to Oct 11, 1920, that I last saw h[illegible] alive on Oct 11 1920, and that death occurred on the date stated above, at 12:20 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Edema
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) Chronic Bronchitis
Chronic (Duration) ..... yrs. 6 mos. ..... ds.

(Signed) L P Gaulter M. D.
10/11 1920 (Address) Montpelier

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... s
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Idaho — DATE OF BURIAL: Oct 13 1920

20. UNDERTAKER: T. M. Williams — ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should write PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 32
Primary Registration District No. 2,136
File No. 32453
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Bennington (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Georgia Stephens

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH: June (Month) 2 (Day) 1919 (Year)

7. AGE: One Yrs. Four Mos. 24 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER George Edward Stephens

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Emma Ruth Green

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Edward Stephens
(Address) Bennington Idaho

15. Filed 12-1-1920 H. W. Terry
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920, to Oct 25 1920, that I last saw her alive on Oct 15 1920, and that death occurred on the date stated above, at 1:10 M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo V. Cudaley M. D.

10-25-1920 (Address) Montpelier

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bennington Idaho. DATE OF BURIAL: 10-28-1920

20. UNDERTAKER: Lorenzo Davis. ADDRESS: Bennington

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 52

Primary Registration District No. 2136

File No. 32454

County of Bear Lake

City of Montpelier, (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas S. Pheltman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	White	Divorced.

6. DATE OF BIRTH

Sept (Month) 3 (Day) 1920 (Year)

7. AGE

30 yrs. 1 mos. 10 ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.*

8. OCCUPATION

(a) Trade, profession or particular kind of work Railroad Engineer,

(b) General nature of industry business, or dstablishment in which employed (or employer) (Oregon Short Line)

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER Robert B. Pheltman.

11. BIRTHPLACE OF FATHER (State or Country) Illinois.

12. MAIDEN NAME OF MOTHER Maggie E. Chaney.

13. BIRTHPLACE OF MOTHER (State or Country) Illinois.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robt B Pheltman

(Address) Pocatello, Idaho.

15.

Filed 12-1- 19 20 — K. K. King

Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Oct (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,

that I last saw h..... alive on ..... 191...,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Cause of death unknown, was found dead in rooming house, dead several hours, post mortem disclosed nothing, cause probably homicide. (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Williams M. XX

Oct 19 20 (Address) County Coroner

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Pocatello, Idaho.	Oct. 20, 1920
20. UNDERTAKER	**ADDRESS**
J. M. Williams	Montpelier, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 32

Primary Registration District No. 2136

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32455

Registered No. .....

1. PLACE OF DEATH

County of Bear Lake

City of Montpelier

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Lora Sommers

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE:

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH ..... (Month) ..... (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. 1 Ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) .....

10. NAME OF FATHER .....

11. BIRTHPLACE OF FATHER (State or Country) .....

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed 12-1-1920 ..... Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. 19 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11-19-20 19.. to 11-19 1920 that I last saw her alive on 11-19 1920 and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Premature birth

Premature Birth Died at Birth

.....(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

.....(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo. F. Ashley M. D.

11-19 1920 (Address) Montpelier, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida

DATE OF BURIAL: Nov 21 1920

20. UNDERTAKER: Fred Sabrook

ADDRESS: Montpelier

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 62
Primary Registration District No. 2136
File No. 32456
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rev. Father John Joseph Burri

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: February 17. 1862.
(Month) (Day) (Year)

7. AGE: 58 Yrs. 9 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Catholic Priest.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Co Lucerne Switzerland

10. NAME OF FATHER: John Joseph Burri.

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: not obtainable

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss K. McMahon.
(Address) Montpelier.

15. Filed 12-15-1920 N. Nolen
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 6 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 1920 to Dec. 6 1920 that I last saw h.m. alive on Dec 3 1920 and that death occurred on the date stated above, at 2:15 P.M.
The CAUSE OF DEATH* was as follows:

Tuberculosis (Pulmonary)
(Duration) 12 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ellis Rackley M. D.
12-7 1920 (Address) Soda Springs, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Shipenna

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Boise Idaho	12/7 1920
20. UNDERTAKER	ADDRESS
Schreiber & Lieuallen	Boise

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Bear Lake
City of Geneva.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2136

File No. 32457
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Violet Lillian Hirschi

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Infant

6. DATE OF BIRTH
Oct (Month) 28 (Day) 1920 (Year)

7. AGE
..... yrs. 1 mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho.

10. NAME OF FATHER Otto Hirschi

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Freida Tuescher

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Otto Hirschi
(Address) Geneva Idaho.

15.
Filed 12-15-1920 W. R. Kemp
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 26 1920 to Dec 4 1920
that I last saw her alive on Sept 26 1920
and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Whooping Cough
..... (Duration) ..... yrs. ..... mos. 8 ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Gaethys M. D.
1920 (Address) Bear Lake Co

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Geneva Idaho | DATE OF BURIAL: Dec 7 1920

20. UNDERTAKER: F. M. Williams | ADDRESS: Montpelier, Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 52
Primary Registration District No. 2136
File No. 32458
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Mani

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH: 7 (Month) 4 (Day) 1 (Year)

7. AGE: 81 yrs. 3 mos. 5 ds.
IF LESS than 1 day how many ..... hs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business, or dstablishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Switzerland

10. NAME OF FATHER: John Escheler

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Annie Bischoff

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Mani
(Address) Montpelier Ida

15. Filed 12-1-20 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 10 (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 3rd 1920, to Dawson once only 1920 that I last saw her alive on July 3rd 1920 and that death occurred on the date stated above, at —M.

The CAUSE OF DEATH* was as follows: Not Known
Senility
Don't Know
(Duration) yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E E Hunsaker M. D.
10-9 1920 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier Ida. DATE OF BURIAL: Oct 11th 1920

20. UNDERTAKER: J M. Williams ADDRESS: Montpelier Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1037
File No. 32459
Registered No. 115

1. PLACE OF DEATH

County of Bingham
City of Blackfoot
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Barbara Parkinson Heese

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Single (Write the word.)

6. DATE OF BIRTH Dec 21 1919 (Month) (Day) (Year)

7. AGE Yrs. 10 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Blackfoot Idaho

10. NAME OF FATHER Fred H Heese

11. BIRTHPLACE OF FATHER (State or Country) Blackfoot Ida.

12. MAIDEN NAME OF MOTHER Edna N. Parkinson

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Fred H Heese

(Address) Blackfoot Ida

15. Filed Nov 4 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH November 2nd 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1920, to Nov 2 1920 **that I last saw h[illegible] alive on** Nov 2 1920 **and that death occurred on the date stated above, at** 4 P. M.

The CAUSE OF DEATH* was as follows:

Laryngismus Stridulus
3 & 4 attacks of a few minutes
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Probably enlarged thymus gland.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

11/3 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Grove City Cemetery — **DATE OF BURIAL** Nov 4 1920

20. UNDERTAKER Ed L. Egli — **ADDRESS** Blackfoot Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 121
Primary Registration District No. 2194

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32460
Registered No. 119

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot Idaho (No. Marcleuse St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Keith Leavitt

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH.
Nov (Month) 5 (Day) 1920 (Year)

7. AGE
..... Yrs. ..... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE
(State or Country) Idaho

10. NAME OF FATHER: Geo. R. Leavitt

11. BIRTHPLACE OF FATHER
(State or Country) Utah.

12. MAIDEN NAME OF MOTHER: Lilly - Lowe

13. BIRTHPLACE OF MOTHER
(State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) G.R. Leavitt
(Address) Marcleuse

15. Filed Nov 9th 1920 Mrs Thelma E. Pierce Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 5 1920, to Nov 7 1920, that I last saw him alive on Nov 7 1920 and that death occured on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Premature Birth
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration ..... yrs. ..... mos. ..... ds.
2008 (Signed) H. J. Simmons M. D.
1920 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moreland Idaho — DATE OF BURIAL: Nov 9 1920

20. UNDERTAKER: G.R. Leavitt — ADDRESS: Blackfoot Moreland

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 32461
Registered No. 120

1. PLACE OF DEATH
County of Bingham
City of Blackfoot (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harvey Moore Tanner
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word!): Married

6. DATE OF BIRTH: March (Month) 14 (Day) 1869 (Year)

7. AGE: 51 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: David Dan Tanner

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Rebecca E. Moore

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Amabja Adams
(Address) American Falls

15. Filed Nov. 9th 1920 Vera Morris Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 4 1920, to Nov 7 1920, that I last saw him alive on Nov 7 1920 and that death occurred on the date stated above, at 2 P M.
The CAUSE OF DEATH* was as follows:

Septicemia

..... (Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Infection of neck (dap)
..... (Duration) ..... yrs. ..... mos. 3 ds.

(Signed) C. W. Beck M. D.
11/8 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ferne City Cemetery — DATE OF BURIAL: Nov 10 1920

20. UNDERTAKER: E & Peck — ADDRESS: Blackfoot

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Thomas Precinct

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 2194

(No. ....., ... St.)

File No. .....

Registered No. 32462

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Warren Evans Baker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 2 (Day) 1920 (Year)

7. AGE: X Yrs. X Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Thomas Idaho

10. NAME OF FATHER: John Baker

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Ida May Davidson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Baker

(Address) Thomas, Idaho

15. Filed Dec 6 1920 Mrs Walter E. Peters Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to Nov 14 1920 that I last saw h.... alive on Nov 14 1920 and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. C. Hamptan M. D.

11/15 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside Cem. DATE OF BURIAL: Nov 16 1920

20. UNDERTAKER: Ed L Egli ADDRESS: Blackfoot

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
(No. ..... St.)

File No. 32463
Registered No. 122

1. PLACE OF DEATH.

County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Catherine Mortensen

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. 5 ~~1839~~ (Month) 18 (Day) 1839 (Year)

7. AGE: 81 Yrs. 6 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: ~~unknown~~ Hans Hansen

11. BIRTHPLACE OF FATHER (State or Country): Denmark ~~unknown~~

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) as to spelling words Martha C. Fish Bankkeeper
(Address) Blackfoot, Idaho.

15. Filed Nov. 19 1920 Mrs Nadine E. Pabst Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 18 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 13 1919, to Nov. 17 1920, that I last saw h[illegible] alive on Nov. 17 1920, and that death occured on the date stated above, at 2 a. M.

The CAUSE OF DEATH* was as follows:
Apoplexy
Sudden
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterial Sclerosis
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ed L Eggli M. D.
11-19 1920 (Address) Blackfoot Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 30 yrs. 1 mos. 26 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence Preston, Oneida Co., Idaho

19. PLACE OF BURIAL OR REMOVAL: Preston Idaho — DATE OF BURIAL: On arrival

20. UNDERTAKER: Ed L Eggli — ADDRESS: Blackfoot

STUBB - YORK CO., PTRS. & BKBR. 24068

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of ..... (No. ....., ... St.)

Registration District No. 121

Primary Registration District No. 1007

File No. 32464

Registered No. 123

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clyde Wilbur Larson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov (Month) 18 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many 8 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Blackfoot Ida

10. NAME OF FATHER: Richard W. Larson

11. BIRTHPLACE OF FATHER (State or Country): Wisconsin

12. MAIDEN NAME OF MOTHER: Edna Jones,

13. BIRTHPLACE OF MOTHER (State or Country): Oklahoma,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Richard W Larson

(Address) Blackfoot

15. Filed Nov 18 1920 Wm Parker E Pierce Local Registrar

SUNS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 18 1920, to Nov 18 1920 that I last saw him alive on Nov 18 1920 and that death occurred on the date stated above, at 11 15 A. M.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) 7th Mo mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W W Beck M. D.

11/18 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery

DATE OF BURIAL: Nov 18 1920

20. UNDERTAKER: Ed L Egli

ADDRESS: Blackfoot.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 32465
Registered No. 124

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. Jamie Add St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christopher Silene
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 17 (Day) 1920 (Year)

7. AGE: ×× Yrs. ×× Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): ×

9. BIRTHPLACE (State or Country): Blackfoot Idaho

10. NAME OF FATHER: Frank M. Silene

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Lenore Bieth an

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. M. Silene
(Address) Blackfoot Idaho

15. Filed Nov. 20 1920 [illegible] E. [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 17 1920, to Nov 20 1920, that I last saw h[illegible] alive on Nov 20 1920, and that death occurred on the date stated above, at 8 A. M.
The CAUSE OF DEATH* was as follows:
Exhaustion

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): Premature Birth 7 mo in utero.
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Simmons M. D.
11/20 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery — DATE OF BURIAL: Nov 20 1920

20. UNDERTAKER: Ed L. Egli — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 32466
Registered No. 125

1. PLACE OF DEATH.
County of Bingham
City of Blackfoot.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bernice Tuttles.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 23 (Day) 1920 (Year)

7. AGE ..... Yrs. ..... Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or 5 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Tuttles

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Rena Beede.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Tuttles
(Address) Shelley Idaho Route 2

15. Filed Nov. 27 1920 Mrs Wales E. P. Deputy
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23. 1920, to Nov 26 1920, that I last saw her alive on Nov 26 1920, and that death occured on the date stated above, at 10P M.

The CAUSE OF DEATH* was as follows:
Premature Birth
6½ mo
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. J. Summerhill M. D.
Nov 27 1920 (Address) Blackfoot Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Groken Idaho
DATE OF BURIAL: Nov 28 1920

20. UNDERTAKER: John Tuttles
ADDRESS:

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRNE - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1 + 1
Primary Registration District No. 1017
File No. 32467
Registered No. 126

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Isahan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 2 (Day) 1907 (Year)

7. AGE: 13 Yrs. 6 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Labarer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Montana

10. NAME OF FATHER: Wilford Isahan

11. BIRTHPLACE OF FATHER (State or Country): Montana

12. MAIDEN NAME OF MOTHER: Lucy Ortiz

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lucy Ortiz
(Address) Idaho Falls Idaho

15. Filed Dec 2 19 20 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Conducted a Coroners Inquest that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Gun Shot Wound in head accidental.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E J Rockwell M. D.
Dec 2 19 20 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls Idaho — DATE OF BURIAL: 12-3 1920

20. UNDERTAKER: E J Rock — ADDRESS: Blackfoot

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 32468
Registered No. 127

1. PLACE OF DEATH
County of Bingham
City of Pingree
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Estella Curtis Weaver
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: March 4 (Month) (Day) 1871 (Year)

7. AGE: 49 Yrs. 9 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Hyrum Utah

10. NAME OF FATHER: Lehi Curtis

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Eliza Barnum

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jonathan H. Weaver
(Address) Pingree Idaho

15. Filed Dec. 8th 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 7 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ Investigated death Dec 8, 1920 19..., to ..... 19.....
~~that I last saw h..... alive on~~ ..... 19.....,
and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Valvular disease heart
Mitral insufficiency.
(Duration) 10 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Bright's Disease
(Duration) 2 yrs. ..... mos. ..... ds.
(Signed) M. E. Patrie M. D.
Dec 8 1920 (Address) County Physician Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Thomas Riverside Cem. DATE OF BURIAL: Dec 10 1920

20. UNDERTAKER: Ed L Egli ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 32469
Registered No. 128

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel Augustus Grover
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: March 30 (Month) (Day) 1920 (Year)

7. AGE: X Yrs. 8 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot Ida.

10. NAME OF FATHER: Wm D. Grover. Jr.

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Ivy May Barnard.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm D. Grover. Jr.
(Address) Blackfoot RFD 3.

15. Filed Dec 14 1920 Mrs Nelia E. Tabor Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1920 to Dec 12 1920 that I last saw him alive on Dec 12 1920 and that death occurred on the date stated above, at 9 P. M.
The CAUSE OF DEATH* was as follows:

Pneumonia (Broncho)

(Duration) ... Yrs. ... mos. 3 ds.
Contributory (Secondary) Bronchitis
(Duration) ... yrs. ... mos. 5 ds.

(Signed) W W Beck M. D.
12/14 1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Grove City Cemetery | DATE OF BURIAL: Dec 14 1920

20. UNDERTAKER: Ed L Egli | ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 32470
Registered No. 139

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. 70 East Center St. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Hewlett Wilde
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 20 (Day) 1844 (Year)

7. AGE: 79 Yrs. 5 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Henry B Wilde

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Newlett

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Louisa Wilde
(Address) E Cor 1 St Blackfoot

15. Filed Dec 16 1920 Mrs Nalin E. Tabor
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1920, to Dec 13 1920 that I last saw him alive on Dec 6 1920 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency

(Duration) Yrs. 5 mos. ds.

Contributory (Secondary) Myocarditis

(Duration) 1 yrs. mos. ds.

(Signed) W W Beck M. D.

12/14 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL, OR REMOVAL: Grove City Cemetery — DATE OF BURIAL: Dec 17 1920

20. UNDERTAKER: Ed L. Egli — ADDRESS: Blackfoot

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
File No. 32471
Registered No. 320

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George P. Howell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE about 73 years.
Yrs. Mos. Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Farmer.
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) New York

10. NAME OF FATHER John Howell

11. BIRTHPLACE OF FATHER (State or Country) Not Known

12. MAIDEN NAME OF MOTHER Not Known

13. BIRTHPLACE OF MOTHER (State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) George Howell
(Address) Blackfoot Ida

15.
Filed Dec 1 1920 Mrs Nalen E. Paine
Local Registrar

SUMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. 13 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1920 to Dec. 13. 1920 that I last saw h[illegible] alive on Dec 13 19[illegible] and that death occurred on the date stated above, at 4 45 a M.

The CAUSE OF DEATH* was as follows:

Sarcoma of Sigmoid
Sarcoma of Sigmoid

(Duration) 1 Yrs. 3 mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Mitchell M. D.
12/3 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grove City Cemetery	Dec 14 1920
20. UNDERTAKER	ADDRESS
[illegible]	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 1 2 1

Primary Registration District No. 2 1 9 4

File No. 32472

Registered No. 97

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

(No. K. F. 20. 1 St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Adelia Y Ramey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: March (Month) 9 (Day) 1835 (Year)

7. AGE: 35 Yrs. 9 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Home Keeper

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Charles Jack

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Mary Nelson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jacob Ramey

(Address) Blackfoot Idaho R#1

15.

Filed Dec-17 1920 Mrs Sharon E. Tew
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1920 to Dec 15 1920 that I last saw her alive on Dec 15 1920 and that death occurred on the date stated above, at 1.50 P.M.

The CAUSE OF DEATH* was as follows:

Exhaustion - Stent

(Duration) unknown Yrs. mos. ds.

Contributory (Secondary) Tuberculosis Lung

(Duration) yrs. mos. ds.

(Signed) H. J. Simmons M. D.

12/17 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Green City cemetery | DATE OF BURIAL: 12-17 1920

20. UNDERTAKER: E J Funk | ADDRESS: Blackfoot

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 214
File No. 32473
Registered No. 132

1. PLACE OF DEATH
County of Bingham
City of Ico
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Naomi Kathleen Andrew
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 22 (Day) 1920 (Year)

7. AGE: X Yrs. 4 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Logan Utah

10. NAME OF FATHER: Andrew Andrew,

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Mary Jones

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Andrew Andrew,
(Address): Rose Ida

15.
Filed Dec 27 19 20 Mrs Naomi E. Hales
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1920, to [redacted] 1926
that I last saw h[redacted] alive on Dec 21 19..
and that death occurred on the date stated above, at 10½ P. M.
The CAUSE OF DEATH* was as follows:

My [redacted] dyed

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] F. Wm Isaac M. D.
12/21 1920 (Address) Bedford Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Logan Utah — DATE OF BURIAL: Dec 24 1920

20. UNDERTAKER: Ed L Egli — ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 32474
Registered No. 133

1. PLACE OF DEATH
County of Bingham
City of Pingree
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joshua Stone

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Aug (Month) 25 (Day) 1877 (Year)

7. AGE: 43 Yrs. 3 Mos. 26 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Caleb Stone

11. BIRTHPLACE OF FATHER (State or Country): England.

12. MAIDEN NAME OF MOTHER: Alice Taylor

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Eliza J Stone
(Address) Pingree

15. Filed ..... 19.. Mrs Ruler E. Wade
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1920, to Dec 21 1920
that I last saw him alive on Dec 13 1920
and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Bright's disease with dropsy

(Duration) 3 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Valv. disease of Heart

(Duration) 10 yrs. ..... mos. ..... ds.

(Signed) W. E. Patic M. D.
12/27 1920 (Address) Blackfoot Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grove City Cem.	Dec 24 1920

20. UNDERTAKER: Eyl L Eyli ADDRESS: Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2TC 1007
(No. St Simmons Hosp W Judicial)

File No. 32475
Registered No. 134

1. PLACE OF DEATH
County of Bingham
City of Blackfoot
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katharine Knudsen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 23 (Day) 1867 (Year)

7. AGE: 53 Yrs. 3 Mos. ds. 27
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Rasmus Christensen

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Marie Hansen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. P. Christiansen
(Address) Blackfoot Idaho

15. Filed Dec 22 1920 Mrs Nellie E. Palmer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1920 to Dec 21 1920 that I last saw her alive on Dec 20 1920 and that death occurred on the date stated above, at 3:30 A.M.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) ..... Yrs. ..... mos. 3 0 ds.

Contributory (Secondary) Pneumonia

(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) J. O. Humphreys M. D.

12/22 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 24 days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? At Ranch NE of town
Former or usual residence Blackfoot Ida R.F.D. No 3.

19. PLACE OF BURIAL OR REMOVAL: Fem. Cem. Greenley — DATE OF BURIAL: 12 23 1920

20. UNDERTAKER: E. J. Funk — ADDRESS: Blackfoot

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 32476
Registered No. 35

1. PLACE OF DEATH
County of Bingham
City of Pingree
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME De Elden Fackrell
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 21 (Day) 1920 (Year)

7. AGE: ... Yrs. ... Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Trenor P. Fackrell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Henrietta L. Parsons

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Trenor P. Fackrell
By W. W. Beck
(Address) Pingree Idaho

15. Filed Dec 23 19 20
Mrs. Nadine E. Parker
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1920, to Dec 23 1920
that I last saw him alive on Dec 21 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... Yrs. ... mos. 2 ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) W. W. Beck M. D.
12/23 1920 (Address) Blackfoot, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Pingree Idaho
DATE OF BURIAL ..... 19.....

20. UNDERTAKER
ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 1007
(No. Cor. Sixth & Bank St.)
File No. 32477
Registered No. 36

1. **PLACE OF DEATH**
County of Bingham
City of Idaho (Blackfoot)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Dora Easterson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	married (Write the word.)

6. **DATE OF BIRTH** February (Month) 5 (Day) 1887 (Year)

7. **AGE** 33 Yrs. 1 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country) Minnesota

10. **NAME OF FATHER** Henry Oscar Johnson

11. **BIRTHPLACE OF FATHER** (State or Country) Wisconsin

12. **MAIDEN NAME OF MOTHER** Hattie Johnson

13. **BIRTHPLACE OF MOTHER** (State or Country) Wisconsin

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Linden O. Johnson
(Address) Plentywood Montana

15.
Filed Dec. 27 1920 Mrs Nalen E. Palmer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** December (Month) 24 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** Aug 5 1913, to date of death 19..., **that I last saw h** er alive on December 24 1920 **and that death occurred on the date stated above, at** 2 P. M.
The CAUSE OF DEATH* was as follows:

tuberculosis and dropsy

(Duration) 17 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dora Easterson (Husband) M. D.
12/27/1920 (Address) Blackfoot, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fern Hill Cemetery	Dec 27 1920

20. **UNDERTAKER** E. J. Funk
ADDRESS Blackfoot Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32479

1. PLACE OF DEATH

County of Bingham

City of Blackfoot

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 121

Primary Registration District No. 107

(No. Cor Linden & Spruce St.)

Registered No. 138

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Unnamed Staines

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Dec (Month) 24 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 1 ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Blackfoot

10. NAME OF FATHER: Howard Staines

11. BIRTHPLACE OF FATHER (State or Country): Nebraska

12. MAIDEN NAME OF MOTHER: Ruby Hilliard

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Howard Staines
(Address) Blackfoot Idaho

15. Filed Dec 20 1920 Mrs Walter E [illegible]
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1920, to Dec 25 1920
that I last saw h alive on Dec 25 1920
and that death occurred on the date stated above, at 12 30 P.M.
The CAUSE OF DEATH* was as follows:
Ex haemorrhage (Heart)

(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) Premature Birth.
(Duration) ... yrs. ... mos. ... ds.

(Signed) H J Simmons M. D.
12/26 1920 (Address) Blackfoot Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Fern Cem	12 26 1920
20. UNDERTAKER	ADDRESS
E J Funk	Blackfoot

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine
City of Hailey,
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2022

File No. 32481
Registered No. 52
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John H. Carey.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.
4. COLOR OR RACE: White.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: about 1855
(Month) (Day) (Year)
7. AGE: 65 yrs. about mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner.
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Virginia.
10. NAME OF FATHER: —
11. BIRTHPLACE OF FATHER (State or Country): —
12. MAIDEN NAME OF MOTHER: —
13. BIRTHPLACE OF MOTHER (State or Country): —
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X John M. Parker
(Address) Ketchum, Ida.
15.
Filed Jan. 1 1921 P. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec. 13 1920,
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec. 5 1920 to Dec. 13 1920
that I last saw h. alive on Dec. 13 1920
and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of bowels.
(Duration) 2 yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Robert H. Wright M. D.
12-14 1920 (Address) Hailey Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ketchum Ida. DATE OF BURIAL: Dec. 15 1920
20. UNDERTAKER: D. Harris. ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32483
Registered No. 46

1. PLACE OF DEATH.
County of Blaine
City of Carey
(No. ....., ... St.)
Registration District No. 57
Primary Registration District No. 2045
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edith Kaniger

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Mar. (Month) 10 (Day) 1862 (Year)

7. AGE: 58 Yrs. 3 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Mr. Walker

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jesse T. Davis
(Address)

15. Filed 12-1 1920 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 31 1920, to June 9 1920, that I last saw h.. alive on June 9 1920 and that death occured on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:
Rock Mountain Tick fever

(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Chronic Interstitial Nephritis
(Duration 3 yrs. 1 mos. ..... ds.
(Signed) Houston & Snyder M. D.
1920 (Address) Carey Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clay Center Kans. DATE OF BURIAL ..... 191...

20. UNDERTAKER: J. E. Harris ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STNR. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2022
File No. 32484
Registered No. 47

1. PLACE OF DEATH.
County of Blaine
City of Bellevue (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry J. Elliott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: March 16 (Month) 1841 (Day) (Year)

7. AGE: 79 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: ✓

11. BIRTHPLACE OF FATHER (State or Country): ✓

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Mrs. Ethel Scharff
(Address) Bellevue Idaho

15. Filed 12-1 1920 R. H. Wright Local Registrar

MEDICAL CERTIFICATE OF DEATH.

Plumer

16. DATE OF DEATH: Oct. (Month) 27. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 7 1920, to Oct 27 1920, that I last saw him alive on Oct 27 1920 and that death occurred on the date stated above, at 4P M.

The CAUSE OF DEATH* was as follows:
Cancer of Bladder

(Duration) 2 yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. E. Plummer M. D.
19 ..... (Address) Hailey Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hailey — DATE OF BURIAL: 10-31 1920

20. UNDERTAKER: P. D. Harris — ADDRESS: Hailey

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine.
City of Gannett.
(No. ....., ... St.)

Registration District No. 57
Primary Registration District No. 2022

File No. 32485
Registered No. 478

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Horace R. White.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married.

6. DATE OF BIRTH: Feb. (Month) 2. (Day) 1882 (Year)

7. AGE: 38 yrs. 8 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer.
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nevada.

10. NAME OF FATHER: Walter G. White.

11. BIRTHPLACE OF FATHER (State or Country): Ohio.

12. MAIDEN NAME OF MOTHER: Catherine Meecham

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. White
(Address) Gannett.

15.
Filed 12-1 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH No. M.D.
Nov. 1st 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Rheumatism of the Heart given by
W.E. White as cause.

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) ..... M. D.
..... 19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Hay Spgs. Cemetery. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: T. B. Harris ADDRESS: Hailey.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 57
Primary Registration District No. 2022
File No. 32486
Registered No. 49

1. PLACE OF DEATH.
County of Blaine.
City of Hailey.
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Christian Justesen.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male.	White.	Single

6. DATE OF BIRTH
Feb. (Month) 16 (Day) 1863. (Year)

7. AGE
57 yrs. 8 mcs. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner.
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Denmark.

10. NAME OF FATHER ✓

11. BIRTHPLACE OF FATHER (State or Country) ✓

12. MAIDEN NAME OF MOTHER ✓

13. BIRTHPLACE OF MOTHER (State or Country) ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pete Justesen.
(Address) Christian, Utah.

15.
Filed 12-1 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

Wright.

16. DATE OF DEATH
Nov. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ✓ 191..., to ✓ 191..., that I last saw h... alive on ✓ 191..., and that death occurred on the date stated above, at ...M.

The CAUSE OF DEATH* was as follows:
Found dead.

(Duration) ... yrs. ... mos. ... ds.

Contributory (Secondary) .....
(Duration) ... yrs. ... mos. ... ds.

(Signed) Robert H. Wright M. D.
11-4 1920 (Address) Co. Coroner.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ...yrs...mos...days. In the State ...yrs...mos...days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Hailey. | DATE OF BURIAL 11-5 1920

20. UNDERTAKER W. D. Harris | ADDRESS Hailey.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Blaine.
City of Hailey,
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 57
Primary Registration District No. 2022
(No. ....., ... St.)

File No. 32488
Registered No. 51
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Reid Ensign.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH: Feb. (Month) 18 (Day) 1843. (Year)

7. AGE: 77 yrs. 9 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Home wife.
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland.

10. NAME OF FATHER: John Reid.

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: ✓

13. BIRTHPLACE OF MOTHER (State or Country): ✓

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) [illegible]
(Address) [illegible]

15.
Filed 12-1 1920 R. H. Wright
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov. (Month) 24. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov-14 1920 to Nov-23 1920
that I last saw her alive on Nov-23 1920
and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Senile Gangrene

(Duration) ..... yrs. 2 mos. ..... ds.
Contributory Chronic Rheumatism
(Secondary)
(Duration) 15 yrs. ..... mos. ..... ds.

(Signed) Robert H. Wright M. D.
11-75 1920 (Address) Hailey, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence.

19. PLACE OF BURIAL OR REMOVAL: Hailey, Ida. DATE OF BURIAL: 11-26. 1920

20. UNDERTAKER: T. D. Harris ADDRESS: Hailey

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7a
Primary Registration District No. 2106
File No. 32489
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Sandpoint.
(No. City Hospital. St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jesse Marion.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June 20 (Month) (Day) 1872 (Year)

7. AGE: 48 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cedar Worker.
(b) General nature of industry, business or establishment in which employed (or employer): Employed.

9. BIRTHPLACE (State or Country): Nebr.

10. NAME OF FATHER: ------- Marion.

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Josie Marion.
(Address) Sandpoint, Ida.

15. Filed Dec 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. 17, 1920.
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1920, to Nov 17 1920; that I last saw him alive on Nov 17 1920, and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Embolism.

(Duration) Yrs. mos. ds.

Contributory (Secondary) Compound fracture of left leg & fracture of right with pneumonia.

(Duration) yrs. mos. 1 ds.

(Signed) O. H. Pugh M. D.

Nov. 24 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida.

DATE OF BURIAL: Nov. 20. 1920

20. UNDERTAKER: B. W. Pugh.

ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32490

Registered No.

1. PLACE OF DEATH

County of Bonner

City of Sandpoint

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79

Primary Registration District No. 2108

(No. City Hospital, Sandpoint St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Chas. H. Foster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Married

6. DATE OF BIRTH: March (Month) 16 (Day) 1882 (Year)

7. AGE: 38 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Henry Foster

11. BIRTHPLACE OF FATHER (State or Country): Mass.

12. MAIDEN NAME OF MOTHER: Rosa Jones

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Henry Foster

(Address) Terrebonne, Oregon.

15. Filed Dec 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June, 1920, to Nov 7 1920, that I last saw him alive on Nov 7 1920, and that death occurred on the date stated above, at 1 a M.

The CAUSE OF DEATH* was as follows:

Carcinoma, Colon,
Sigmoid flexure

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. H. Page M. D.

Nov 24 1920. (Address) Sandpoint Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Terrebonne, Oregon.

DATE OF BURIAL 19

20. UNDERTAKER: B. W. Pugh

ADDRESS: Sandpoint

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32491
Registered No.

1. PLACE OF DEATH

County of Bonner

City of Westmond

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78

Primary Registration District No. 2155

(No. Westmond, Ida. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Christina Miller.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	White	Widowed.

6. DATE OF BIRTH: Nov. 18, 1851. (Month) (Day) (Year)

7. AGE: 69 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany.

10. NAME OF FATHER: L. Schramm.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Unknown.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert C. Ullman.
(Address) Westmond, Ida.

15. Filed Dec 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 20. 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3 1920, to Nov 7 1920, that I last saw her alive on Nov 7 1920, and that death occurred on the date stated above, at ✓ M.

The CAUSE OF DEATH* was as follows:

Embolism, Cerebral,

(Duration) Yrs. 2 mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) O. H. Page M. D.

Nov. 29 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: York Mills, Minn. DATE OF BURIAL 19

20. UNDERTAKER: B.W.Pugh, ADDRESS: Sandpoint, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32492
Registered No.

1. PLACE OF DEATH

County of Bonner
City of Kootenai
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2155
(No. Kootenai, Ida. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Woodrow Gunder Rice.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Dec. (Month) 22 (Day) 1918 (Year)

7. AGE: 2 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER. Gunder Rice

11. BIRTHPLACE OF FATHER (State or Country) Norway

12. MAIDEN NAME OF MOTHER Augusta Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Gunder Rice
(Address) Kootenai, Ida.

15. Filed Dec 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26 1920 to Dec 2 1920 that I last saw him alive on Nov. 30 1920 and that death occurred on the date stated above, at 5:00 M.

The CAUSE OF DEATH* was as follows:

meningitis

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary) pneumonia

(Duration) yrs. mos. 8 ds.

(Signed) N. P. Wallentine M. D.

Dec. 2, 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida.
DATE OF BURIAL: Dec. 8 1920

20. UNDERTAKER: B. W. Pugh
ADDRESS: Sandpoint.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32493

Registered No.

Registration District No. 78

Primary Registration District No. 210

1. PLACE OF DEATH

County of Bonner

City of Humbird Lr Camp #1

If death occurs away from usual residence, give facts called for under special information.

(No. Humbird Lumber Camp #1 St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Harry LE Fever

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Single

6. DATE OF BIRTH: Aug. (Month) 27 (Day) 1897 (Year)

7. AGE: 23 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Woodsman
(b) General nature of industry, business or establishment in which employed (or employer): Employee

9. BIRTHPLACE (State or Country): Iowa.

10. NAME OF FATHER: Jno Le Fever.

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Lizzie Campbell.

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jno. Le Fever,
(Address) New Port, Wash.

15. Filed Dec 5 19 FLOYD G. WENDLE Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
Never saw him alive

The CAUSE OF DEATH* was as follows:
Accidental Death at Humbird Lmb Co, Camp No.1.while unloading logs,Log struck him in Thoracic region crushing both Clavicles, Sternum and several Ribs. Death was Instantaneous, due to internal hemorrhage and shock.
(Duration) yrs. mos. ds.

(Signed) B.W. Pugh, Dep Coroner. M. D.
Dec, 1, 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Newport, Wash. DATE OF BURIAL ..... 19.....

20. UNDERTAKER: B. W. Pugh ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32494
Registered No.

1. PLACE OF DEATH

County of Bonner

City of Sandpoint, Ida. (No. Lake & 2nd St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7P

Primary Registration District No. 2/53

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elsie Ina Willi.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single. (Write the word.)

6. DATE OF BIRTH: June (Month) 15 (Day) 1907 (Year)

7. AGE: 13 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: School Girl.

(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: Phillip Willi.

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Ida Kujawaski.

13. BIRTHPLACE OF MOTHER (State or Country): Germany.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Phil Willi.

(Address) Sandpoint, Ida.

15. Filed Dec 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 21. (Day) -20. 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920, to Nov 21 1920 19, that I last saw her alive on Nov. 20 1920 19, and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(Duration) 1 Yrs. --- mos. --- ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) C. P. Getzloff M. D.

Nov 26 1920. (Address) Priest River, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint, Ida. DATE OF BURIAL: Nov. 24, 1920.

20. UNDERTAKER: B.W.Pugh, ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 78
Primary Registration District No. 2155
File No. 32495
Registered No.

1. PLACE OF DEATH

County of Bonner.
City of Sandpoint.
(No. 350 So. Florence St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. Francis Glover.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: July, 3, 1861 (Month) (Day) 1 (Year)

7. AGE: 59 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer): At Home.

9. BIRTHPLACE (State or Country): Penna.

10. NAME OF FATHER: Jno Barnes.

11. BIRTHPLACE OF FATHER (State or Country): Penna.

12. MAIDEN NAME OF MOTHER: Cardelia Kennedy.

13. BIRTHPLACE OF MOTHER (State or Country): Penna.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Will French,
(Address) Sandpoint, Ida.

15. Filed Dec 8 1920

FLOYD G. WENDLE
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov, 3, -20. 19 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1920, to Nov 2 1920 that I last saw her alive on Nov 2 1920, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Metastasis Carcinomas

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E T Anderson M. D.

Nov. 16 1920. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sandpoint. Ida. DATE OF BURIAL: Nov. 9, 1920.

20. UNDERTAKER: B. W. Pugh, ADDRESS: Sandpoint, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Bonner

City of Laclede Ida (No. * *, * * * St.)

Registration District No. 81

Primary Registration District No. 2058

File No. 832496

Registered No. 29

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Harrison Foster

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	widower

6. DATE OF BIRTH.

Apr (Month) 1 (Day) 1850 (Year)

7. AGE. 70 Yrs. 8 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER * * Foster

11. BIRTHPLACE OF FATHER (State or Country) Pennsylvania

12. MAIDEN NAME OF MOTHER Bond

13. BIRTHPLACE OF MOTHER (State or Country) not known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Floyd Foster

(Address) Laclede Ida.

15. Filed Dec 27 1920 F W Didier Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1920, to Dec 19 1920, that I last saw him alive on Dec 19 1920, and that death occured on the date stated above, at 2:15 P M.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

* * (Duration) * * Yrs. * * mos. 6 ds.

Contributory (Secondary) asthma

(Duration 20 yrs. ..... mos. ..... ds.

(Signed) F W Didier M. D.

Dec 20 1920 (Address) Laclede Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sandpoint, Ida	Dec 21 1920

20. UNDERTAKER	ADDRESS
B. N. Pugh. By Mrs. B. N. P.	Sandpoint

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

YORK CO., PTRS. & STNRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 85

County of Bonner

Primary Registration District No. 2185

File No. 12497

City of Priest River,

(No. ....., ... St.)

Registered No. 26

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Scott Wallace

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Jan (Month) 27 (Day) 1884 (Year)

7. AGE: 37 Yrs. 10 Mos. 22 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Oscer B Wallace

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Laura B.Scott

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs W S. Wallace

(Address) Newport Wash

15. Filed Jan 1 1921 C. P. Gettys Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ----------19....., to ----------19....., that I last saw h.im alive on Dec 18 1920, and that death occurred on the date stated above, at ---- M.

The CAUSE OF DEATH* was as follows:

Fatty Degeneration of the Heart
and cardiac aneurysm.
(Found on post mortem)

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Gettys M. D.

Dec 1920 (Address) Priest river, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spokane Wash	Dec 27 1920

20. UNDERTAKER	ADDRESS
William Davis	Newport Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32499

Registered No. 133

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls (No. ....., ... St.)

Registration District No. 73

Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Flonnie Melva Eaton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: January (Month) 3 (Day) 1906 (Year)

7. AGE: 14 Yrs. 11 Mos. 13 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iona, Ida

10. NAME OF FATHER: Lewis Eaton

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Lina Cook

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Eaton

(Address) Shelley Rt 2 Ida

15. Filed Dec 30 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1920, to Dec 21 1920, that I last saw her alive on Dec 21 1920, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. W. Cline M. D.

12/21 1920 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Taylor Ida — DATE OF BURIAL: 12/25 1920

20. UNDERTAKER: C. Dunwoody — ADDRESS: Ida Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

Registration District No. 73

Primary Registration District No. 2107

(No. ....., ... St.)

File No. 32500

Registered No. 176

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Avery

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Married

6. DATE OF BIRTH: Jan (Month) 7 (Day) 1868 (Year)

7. AGE: 52 Yrs. 11 Mos. 75 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER L. Vanlaeven

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER Janet Wilson

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C E Dunwoody

(Address) Ida Falls

15. Filed Dec 3 1920 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1920, to Dec 10 1920

that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C E Dunwoody M. D.

12/14 1920 (Address) Ida Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Lewisville, Ida	12/16 1920

20. UNDERTAKER	ADDRESS
C E Dunwoody	Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

1. [illegible] OF DEATH

County of Bonneville

City of Idaho Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3

Primary Registration District No. 2 1 4 3

2. FULL NAME Amasa Watts

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32502

Registered No. 175

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: March 17 1869 (Month) (Day) (Year)

7. AGE: 51 Yrs. 9 Mos. 0 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ind.

10. NAME OF FATHER: John G. Watts

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Harriet Jones

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. E. Watts
(Address) Cahopolis, Mich

15. Filed Dec 30 1920 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 17 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920 to Dec 17 1920
that I last saw h..... alive on ..... 19..
and that death occurred on the date stated above, at 7-30 P.M.
The CAUSE OF DEATH* was as follows:

Typhoid fever

(Duration) Yrs. mos. ds.

Contributory (Secondary) Cerebral Hemorrhage

(Duration) yrs. mos. 2 ds.

(Signed) [illegible] M. D.

12/14 1920 (Address) Idaho Falls Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Ind. DATE OF BURIAL: 12/14 1920

20. UNDERTAKER: [illegible] ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 1 - 0
(No. ..... St.)

File No. 32502
Registered No. 174

1. PLACE OF DEATH

County of Bonneville
City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Geo. Mrs Thompson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Apr 25 1848 (Month) (Day) (Year)

7. AGE: 72 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ?
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Geo. Thompson

11. BIRTHPLACE OF FATHER (State or Country): ~~Eng~~ Ireland

12. MAIDEN NAME OF MOTHER: Ann Bailey

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Byrd
(Address) R D 6 City

15. Filed Dec 30 1926 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 15 1926 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 11:30 a M.
The CAUSE OF DEATH* was as follows:

Carcinoma of face
Un medical attendance

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.
Dec 30 1926 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Aldon Ida — DATE OF BURIAL: 11/18 1926

20. UNDERTAKER: [illegible] Idaho Falls — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32503

Registered No. 173

1. PLACE OF DEATH

County of Bonneville

City of Idaho Falls

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 73

Primary Registration District No. 2170

(No. ..... St.)

2. FULL NAME Veral Dismont Chadburn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Infant

6. DATE OF BIRTH Sept (Month) 10 (Day) 1920 (Year)

7. AGE 0 Yrs. 1 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. H. Chadburn

11. BIRTHPLACE OF FATHER (State or Country) Utah.

12. MAIDEN NAME OF MOTHER Mary Hardy

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) J. H. Chadburn

(Address) Idaho Falls

15. Filed Dec 3. 1920 W. Pumant Local Registrar

Dr Wilson

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 10 1920, to Sept. 20 1920, that I last saw h[illegible] alive on Sept 20 1920, and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:

Fluid deformity at birth — Rachischisis

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) N. L. Wilson M. D.

11/6 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grant Idaho	10/29 1920

20. UNDERTAKER [illegible] Underwood ADDRESS Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2 1 0 -0
File No. 32504
Registered No. 172

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME David R. Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Apr 30 1888 (Month) (Day) (Year)

7. AGE: 32 Yrs. 6 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Cement Worker
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Richmond, Ill

10. NAME OF FATHER: J. N. Smith

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Charlotte Smith

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) T. E. Smith
(Address) Idaho Falls Ida

15. Filed Nov 3 a ..... 19 20 — C. Kennard, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:
Accidentally killed by being caught between Cog wheels while oiling machinery at McGuire Paving plant. (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) ..... (Duration) ..... yrs. ..... mos. 0 ds.

(Signed) E E Dunwoody M.D.
11/11 19 20 (Address) Ida Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Ship

19. PLACE OF BURIAL OR REMOVAL: Richmond Ill — DATE OF BURIAL: 11/11 19 20

20. UNDERTAKER: E E Dunwoody — ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 32505
Registered No. 171

1. PLACE OF DEATH.
County of Bannock
City of Ida Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Thompson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Nov (Month) 4 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Aarond M Thompson

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Fern Ridley

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A M Thompson
(Address) Leval, Ida

15. Filed Nov 30 1920 W Truman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Influenza
Contributory pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C Guy Truman M. D.
12/30 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ida Falls
DATE OF BURIAL: 11/22/1920

20. UNDERTAKER: C E Linnwood
ADDRESS: Ida Falls

Dr Spencer

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 32506
Registered No. 170

1. PLACE OF DEATH
County of Bonneville
City of Ida Falls
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Wm Smith
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 4 (Day) 1870 (Year)

7. AGE: 07 Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Smith

11. BIRTHPLACE OF FATHER (State or Country): Austria

12. MAIDEN NAME OF MOTHER: Lena Robertson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Smith
(Address) City

15. Filed Dec 30 1920 W. Truman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1920, to Dec 28 1920, that I last saw him alive on Dec 28 1920 and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:
Bronchopneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 5 ds.

(Signed) Geo. A. Applegate M.D.
1920 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 12/30 1920

20. UNDERTAKER: C. E. Linwoodey — ADDRESS: Ida Falls

Dr. Applegate

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2164
File No. 32507
Registered No. 169

1. PLACE OF DEATH

County of Bannock
City of Idaho Falls (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys Eliz Tufford

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: May (Month) 30 (Day) 1911 (Year)

7. AGE: 9 Yrs. 5 Mos. 13 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: E H Tufford

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Bessie Severs

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): E H Tufford
(Address): R 2 Box City

15. Filed Dec 30 1920 C Kennard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 13 1920, to Nov 13 1920 that I last saw him ~~alive~~ dead on Nov 13 1920 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) ..... Yrs. 2 mos. — ds.

Contributory (Secondary): Typhoid Fever

(Duration) ..... yrs. 4 mos. — ds.

(Signed) Jabez Wirt M. D.

11/15 1920 (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 11/15 1920

20. UNDERTAKER: C C Linwood — ADDRESS: Ida Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 32508
Registered No. 167

1. PLACE OF DEATH

County of Bannock
City of Ida Falls
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Clark

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.) Infant

6. DATE OF BIRTH Dec (Month) 4 (Day) 1920 (Year)

7. AGE 0 Yrs. 0 Mos. 0 ds.

IF LESS than 1 day how many 2 hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho Falls

10. NAME OF FATHER L. E. Clark

11. BIRTHPLACE OF FATHER (State or Country) Cal.

12. MAIDEN NAME OF MOTHER Margaret Duncan

13. BIRTHPLACE OF MOTHER (State or Country) Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. E. Clark

(Address) Ida Falls

15. Filed Dec 30 1920 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 4 1920, to Dec 4 1920 that I last saw him alive on Dec 4 1920 and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:

Prematurity

1 mo 2 months Premature

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. P. Barry Hatch M. D.

Dec 30 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Idaho Falls — **DATE OF BURIAL** 1/6 1920

20. UNDERTAKER [illegible] Underwood — **ADDRESS** Ida Falls

Dr Hatch

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2107
File No. 32509
Registered No. 167

1. PLACE OF DEATH
County of Bannock
City of Inkom
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria E. Jenkins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1874 (Year)

7. AGE: 46 Yrs. 7 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm Johns

11. BIRTHPLACE OF FATHER (State or Country): ?

12. MAIDEN NAME OF MOTHER: Sarah Ann Ashton

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. C. Dunwoody
(Address) [illegible] - City

15. Filed Dec 30 1920 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 28 1920, to Dec 23 1920, that I last saw h.. alive on Dec 23 1920 and that death occurred on the date stated above, at 2a M.

The CAUSE OF DEATH* was as follows:
Diabetic Coma
34 hrs
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Diabetes Mel.
(Duration) several yrs. ..... mos. ..... ds.

(Signed) H. E. Jenkins M. D.
Dec 30 1920 (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Idaho Falls	12/28/1920

20. UNDERTAKER	ADDRESS
C. C. Dunwoody	Ida Falls

H. E. Jenkins

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2017
File No. 32510
Registered No. 166

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Lucille Foster
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Single

6. DATE OF BIRTH: August (Month) 21 (Day) 1919 (Year)

7. AGE: 1 Yrs. 3 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William Foster

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Mary Lucille Foster

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Foster
(Address) Idaho Falls

15. Filed Dec 16 1920 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 8 (Day) 1919 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-6 1920, to 12-8- 1920
that I last saw h.. alive on 12-7- 1920,
and that death occurred on the date stated above, at 10:9 M.
The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) H. C. Hallsted M. D.
19..... (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)
At place of death ..... yrs. ..... mos. ..... days. State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence Idaho Falls

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rose Hill Cemetery	Dec. 10 1920
20. UNDERTAKER	ADDRESS
Taylor-Elleson Undtg	Idaho Falls

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 32511
Registered No. 167

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. Spencer Hosp St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank Roberts
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	Colored	Single

6. DATE OF BIRTH Dont Know, 1
(Month) (Day) (Year)

7. AGE About 40,
Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Janitor,
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Dont Know

10. NAME OF FATHER " "

11. BIRTHPLACE OF FATHER (State or Country) " "

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Smith
(Address) Idaho Falls Ida

15. Filed Sept 7 19 20 W Simmons
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Sept 1 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....19...., to ....19....
that I last saw h.... alive on ....19....,
and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows: Revolver wound Abdomen

....(Duration) ....Yrs. ....mos. ....ds.
Contributory (Secondary)
....(Duration) ....yrs. ....mos. ....ds.

(Signed) H Dr Jones M. D.
....19.... (Address) Idaho Falls, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Rose Hill Idaho Falls | DATE OF BURIAL Sept 6 1920

20. UNDERTAKER Cliff Hayes | ADDRESS Idaho Falls Ida

Dr Jones

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2170
File No. 32512
Registered No. 164

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Phillip Cassidy

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Aug 22 1845
(Month) (Day) (Year)

7. AGE: 30 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Druggist
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake Utah

10. NAME OF FATHER: Jno Cassidy

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Celia Sheridan

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thos Cassidy
(Address) Salt Lake Utah

15. Filed Dec 19 1920 C. A. Tennant Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from December 3 1920 to Dec. 3 1920, that I last saw h. in alive on Dec 3 1920, and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Probably heart failure. Man collapsed while sweeping the floor died in 10 minutes.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Mary L. Willcox M. D.

12/5 1920 (Address) Idaho Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salt Lake Ut. DATE OF BURIAL: Dec. 1920

20. UNDERTAKER: Cliff Hayes ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 21 1-2
File No. 32513
Registered No. 163

1. PLACE OF DEATH,
County of Bonneville
City of Idaho Falls
(No. Spencer Hosp. St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lawrence Van Dorn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: Dec 17 1904 (Month) (Day) (Year)

7. AGE: 16 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy,
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: C B. Van Dorn.

11. BIRTHPLACE OF FATHER (State or Country): Montana.

12. MAIDEN NAME OF MOTHER: Bertha Arris.

13. BIRTHPLACE OF MOTHER (State or Country): Canada.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mr. Chas. VanDorn,
(Address) Swan Valley, Ida.

15. Filed Nov 1 1920 C M Kennard Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 10 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 1- 1920 to Sept 10 1920 that I last saw h[illegible] alive on Sept 10 1920 and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Uremic Intoxication
Intestinal obstruction

(Duration) ? Yrs. mos. ds.
Contributory (Secondary) Lobar Pneumonia R Lung

(Duration) yrs. ? mos. ds.

(Signed) C M Kennard M. D.
Nov 1 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Idaho Falls | DATE OF BURIAL: Sept 11 1920

20. UNDERTAKER: Cliff Hayes | ADDRESS: Idaho Falls Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Kinna, Mrs. W. Spencer.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 79

Primary Registration District No. 2156

File No. 32514

Registered No.

County of

City of Boundary

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

If death occurred outside usual residence, give facts called for under special information.

(No. , St.)

Indian Village

2. FULL NAME Adam Stanislas.

PERSONAL AND STATISTICAL PARTICULARS

Adam Stanislas

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)
Male	Indian	Widower

6. DATE OF BIRTH

(Month) (Day) 1 1843 (Year)

7. AGE

77 yrs. mos. ds.

IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry business, or dstablishment in which employed (or employer) Indian Rancher

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER Boundary Co. Idaho.

11. BIRTHPLACE OF FATHER (State or Country) Stanislas

12. MAIDEN NAME OF MOTHER Idaho

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) M. J. Fisher

(Address) Bonners Ferry Ida.

15.

Filed Dec. 13th. 1920

E E Fry.
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH

Dec. Sunk (9th.) 1920

(Month) (Day) (Year)

17. I HEREBY CERTIFY that I attended deceased from 191..., to 191...,

that I last saw h alive on 191...,

and that death occurred on the date stated above, at Im Dec. 8, 1920 M.

The CAUSE OF DEATH* was as follows:

Old Age

(Duration) yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) M. D.

19.... (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bonners Cemetery	Dec 11 1920
20. UNDERTAKER	**ADDRESS**
Dunham	Bonners Ferry Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Boundary
City of Naples
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 79.
Primary Registration District No. 2156.
(No. ....., ... St.)

File No. 32515
Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Condinos Gust Fazors

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Aug (Month) 15 (Day) 1882 (Year)

7. AGE: 38 yrs. 4 mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumberman
(b) General nature of industry business, or establishment in which employed (or employer): Logging

9. BIRTHPLACE (State or Country): Greece

10. NAME OF FATHER: Lisis Fazors

11. BIRTHPLACE OF FATHER (State or Country): Greece

12. MAIDEN NAME OF MOTHER: Helen Skenderis

13. BIRTHPLACE OF MOTHER (State or Country): Greece

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Fazors
(Address) Naples Idaho

15.
Filed Dec. 27- 1920. E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Killed from Gun Shot wound

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. D. Simonds Coroner M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Sand Point Ida. | DATE OF BURIAL: 12/28 1920

20. UNDERTAKER: E. R. Storey | ADDRESS: Bonners Ferry

SYMS - YORK CO., PTRS. & SDRS. 19780

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 215-6.
File No. 32516
Registered No.

1. PLACE OF DEATH
County of Boundary
City of Bloeksmanton (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Charles Sevesley
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced

6. DATE OF BIRTH: November (Month) ..... (Day) 1 (Year)

7. AGE: 47 Yrs. ..... Mos. ..... ds. (About.)
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: James Sevesley

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sally Spalding

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. A. Sevesley
(Address) Yahk B.C.

15. Filed 12/28/1920. E E Fry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 19 1920, to November 25 1920, that I last saw him alive on November 25 1920, and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) — yrs. — mos. — ds.

(Signed) L. T. Faucett M. D.
12/28/1920 (Address) Bonners Ferry Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Yahk, B. C. - Canada | DATE OF BURIAL ..... 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 79.
Primary Registration District No. 5156.
File No. 32517
Registered No.

1. PLACE OF DEATH.
County of Boundary
City of Bonners Ferry (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edwin O Westerlund

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH: Oct (Month) 9 (Day) 1904 (Year) 1904

7. AGE: 16 yrs. 1 mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Scholar
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wise.

10. NAME OF FATHER: Eric Westerlund

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Christine Bystedt

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eric Westerlund
(Address) Bonners Ferry Ida

15. Filed Dec. 1st. 1920. E E Fry. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Drowning (accidental)

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E E Fry M. D.
12/1/1920 (Address) Bonners Ferry, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bonners Ferry Ida — DATE OF BURIAL: Dec 2 1920

20. UNDERTAKER: A B Rodney — ADDRESS: Bonners Ferry Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 2129
(No. ..... St.)

File No. 32518
Registered No. .....

1. PLACE OF DEATH
County of Butte
City of Arco
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Warren David Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: July (Month) 9 (Day) 1894 (Year)

7. AGE: 26 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Murray, Idaho

10. NAME OF FATHER: John K. Smith

11. BIRTHPLACE OF FATHER (State or Country): Maine

12. MAIDEN NAME OF MOTHER: Emma Mance

13. BIRTHPLACE OF MOTHER (State or Country): Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alice Smith
(Address) Arco, Idaho

15. Filed 11/25 19 22 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 24 (Day) 19 22 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21 19 22 to Nov 24 19 22
that I last saw h.im alive on Nov 24 19 22
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Fractured Skull & Nose
(Duration) ..... yrs. ..... mos. 2 ds.

(Signed) E. W. Fox M. D.
11/25 19 22 (Address) Arco, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moore, Idaho — DATE OF BURIAL: 11/26 19 22

20. UNDERTAKER: E. H. Hendrick — ADDRESS: Arco Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32519

Registered No.

Registration District No. 59

Primary Registration District No. 2129

1. PLACE OF DEATH

County of Butte

City of Arco (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Francis Blattner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Single

6. DATE OF BIRTH: November 11 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. ..... da. IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arco, Idaho

10. NAME OF FATHER: Harold Henry Blattner

11. BIRTHPLACE OF FATHER (State or Country): Bountiful Utah

12. MAIDEN NAME OF MOTHER: Maud Evelin Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Hyrum Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harold Blattner
(Address) Arco Idaho

15. Filed 11/8 1920 Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 7 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/7 1920, to 11/7 1920 that I last saw him alive on 11/7 1920 and that death occurred on the date stated above, at 6.15 P. M.

The CAUSE OF DEATH* was as follows:

Premature (7 mo) Inanition

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

11/7 1920 (Address) Arco, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arco, Idaho — DATE OF BURIAL: 11/8 1920

20. UNDERTAKER: W. C. Crest — ADDRESS: Arco, Idaho

N. B.—Every item of information should be carefully examined. Age should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4 / 8
Primary Registration District No. 2005
File No. 32520
Registered No. 744

1. PLACE OF DEATH

County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ellen O Roke

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: widow (Write the word.)

6. DATE OF BIRTH: Aug. 3- (Month) (Day) 1848 (Year)

7. AGE: 72 Yrs. 5 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois.

10. NAME OF FATHER: James Frame.

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Elizabeth Fox

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. L. D. Pyeman
(Address) McCourtie Kansas.

15. Filed Dec. 14- 1920 John H. Meyer
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19....., to ..... 19.....,
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 3 P. M.
The CAUSE OF DEATH* was as follows:
acute dilitation of the heart
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C V Peckham Coroner M. D.
19..... (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lawrence, Kansas — DATE OF ~~BURIAL~~ shipment 12- 15 1920

20. UNDERTAKER: C V Peckham — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 1 7
Primary Registration District No. 2005
File No. 32521
Registered No. 145

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harold Sherman Sarratt
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: April 22 1911 (Month) (Day) (Year)

7. AGE: 9 Yrs. 7 Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: S. W. Sarratt

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Cora Fasley

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): S. W. Sarratt
(Address): Caldwell Ida.

15. Filed Dec. 15 1920 — John L. Meyers, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4 1920, to Dec. 13 1920
that I last saw him alive on Dec. 4 1920
and that death occurred on the date stated above, at 6 P. M.
The CAUSE OF DEATH* was as follows:

Disease of Heart following
severe attack of Diphtheria
(Duration) ..... Yrs. ..... mos. 23 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Henry M. D.
19 (Address) Caldwell Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 12-15 1920
20. UNDERTAKER: C. F. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. #1 *
Primary Registration District No. 2005
File No. 32522
Registered No. 146

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claude W. Ragan

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Strike out the words not applicable. married
6. DATE OF BIRTH: Feb. (Month) 8 (Day) 1885 (Year)
7. AGE: 35 Yrs. 10 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Barber.
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Illinois.
10. NAME OF FATHER: John W. Ragan
11. BIRTHPLACE OF FATHER (State or Country): Illinois.
12. MAIDEN NAME OF MOTHER: Bell Grady
13. BIRTHPLACE OF MOTHER (State or Country): Tenn.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Carl T. Ragan
(Address) Fremont Neb
15. Filed Dec. 20 1920 John S. Meyers. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1920 to Dec 19 1920 that I last saw h[illegible] alive on Dec 18 1920 and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis
(Duration) 2 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) M. Daley M. D.
12-20 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Anna Illinois | DATE OF BURIAL ..... 19.....
20. UNDERTAKER: C. V. Peckham | ADDRESS: Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Caldwell

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 5

Primary Registration District No. 1005

(No. ..... St.)

File No. 32523

Registered No. 147

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Dewey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 20 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Geo W Dewey

11. BIRTHPLACE OF FATHER (State or Country): Mich

12. MAIDEN NAME OF MOTHER: Helen Metcalf

13. BIRTHPLACE OF MOTHER (State or Country): Mont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G W Dewey

(Address) 1520 Blaine

15. Filed Dec. 20 1920 John L. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 20 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1920 to Dec 19 1920 that I last saw h.r alive on Dec 19 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Asphyxia — premature birth

..... (Duration) ..... Yrs. ..... mos. 0 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. 0 ds.

(Signed) S W Dudley M. D.

12/20 1920 (Address) Caldwell - Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 12-22 1920

20. UNDERTAKER: CASE FURNITURE CO. — ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51068

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 3
Primary Registration District No. 2005
File No. 32524
Registered No. 148

1. PLACE OF DEATH

County of Canyon
City of Caldwell
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Clarine Tidwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	single

6. DATE OF BIRTH: Oct (Month) 12 (Day) 1911 (Year)

7. AGE: 9 Yrs. 2 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Wm J. Tidwell

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Emma E. Jones

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. J. Tidwell
(Address) Caldwell Ida.

15. Filed Dec. 21 1920 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to Dec 20 1920 that I last saw her alive on Dec 20 1920 and that death occurred on the date stated above, at 5:00 P. M.

The CAUSE OF DEATH* was as follows:
Gunshot wound in left side of abdomen
(Duration) ..... Yrs. ..... mos. 1/2 hour ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. M. Talley M. D.
12-20 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wellington, Utah — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: C. T. Peckham — ADDRESS: Caldwell

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dudley

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 3

Primary Registration District No. 2005

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32525

Registered No. 149

1. PLACE OF DEATH

County of Canyon

City of Greenleaf (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mable E. Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH: June (Month) 5 (Day) 1884 (Year)

7. AGE: 36 Yrs. 6 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Teacher
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): North Dakota

10. NAME OF FATHER: Allen M. Howard

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Ida M. Muggy

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Robert J. Howard
(Address) Emmett Idaho

15. Filed 12-28-1920 John S. Meyer Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1920 (Year)
December 25 1926

17. I HEREBY CERTIFY, That I attended deceased from Dec 17 1920, to Dec. 25 1920, that I last saw h. alive on Dec. 25 1920, and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia - double

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Coma - Uremia Tricuspid insufficiency

..... (Duration) 6 yrs. — mos. — ds.

(Signed) J. W. Dudley M. D.

19..... (Address) Caldwell Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Cem	12-28-1920
20. UNDERTAKER	**ADDRESS**
V. Peckham	Caldwell Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32526

Registered No. 178

1. PLACE OF DEATH

Registration District No. 8

Primary Registration District No. 2005

County of Canyon

City of Middleton (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Peter Neth

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
male	white	Married (or Widowed)

6. DATE OF BIRTH: May (Month) 7 (Day) 1852 (Year)

7. AGE: 68 Yrs. 7 Mos. 18 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Michael Neth

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary M. Neth
(Address) Middleton Ida

15. Filed 12-27-1920 John C. Meyers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Dec 25 1920
that I last saw h.. alive on Dec 23 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Senility
(Duration) ..... yrs. 2 mos. ..... ds.

(Signed) J. W. Coe M. D.
12/27 1920 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Middleton Cem	12-27 1920
20. UNDERTAKER	ADDRESS
V. Peckham	Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 9
Primary Registration District No. 2005
File No. 32821
Registered No. 151

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ronald Benjamin Vance
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 23 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Robert G. Vance

11. BIRTHPLACE OF FATHER (State or Country) Tennessee

12. MAIDEN NAME OF MOTHER Zona Justice

13. BIRTHPLACE OF MOTHER (State or Country) Georgia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. C. Vance
(Address) R 2

15. Filed Dec. 29 1920 John L. Mayes Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 29 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1920, to Dec 29 1920
that I last saw ~~him~~ alive on Dec 28 1920,
and that death occurred on the date stated above, at 7A M.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) none
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. Montgomery M. D.
Dec 29 1920 (Address) Caldwell. Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: ..... 19..

20. UNDERTAKER: CASE FURNITURE CO.
ADDRESS: Caldwell

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Canyon
City of Wilder
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 3
Primary Registration District No. 2005
(No. ....., ... St.)

File No. 32528
Registered No. 152
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter Clark Patterson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.)

6. DATE OF BIRTH: Sept (Month) 1 (Day) 1920 (Year)

7. AGE: ..... yrs. 3 mos. 29 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wilder Idaho

10. NAME OF FATHER: Walter Bert Patterson

11. BIRTHPLACE OF FATHER (State or Country): Hutchenson Kansas

12. MAIDEN NAME OF MOTHER: Emma Keith

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C W Patterson
(Address) Boise Ida R5

15. Filed Dec. 30 1920 John I. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Called in, after baby ....., 191..., that I last saw him alive on Dec. ....., 191..., and that death occurred on the date stated above, at 2 a M.

The CAUSE OF DEATH* was as follows:
Bronchio Pneumonia

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A B Bouck M. D.
19..... (Address) Wilder Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Wilder Ida
DATE OF BURIAL: Dec 30 1920

20. UNDERTAKER: C. Beckham
ADDRESS: Wakarusa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

cole

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32029
Registered No. 153

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
Registration District No. 9
Primary Registration District No. 1005
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence A. Ward
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: June (Month) 15 (Day) 1878 (Year)

7. AGE: 42 Yrs. 11 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Jewelry
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Yonkers New York St

10. NAME OF FATHER: Richard Ward.

11. BIRTHPLACE OF FATHER (State or Country): New York. State

12. MAIDEN NAME OF MOTHER: Naomi Earle Ward.

13. BIRTHPLACE OF MOTHER (State or Country): New York. St.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. R. Fuller
(Address) Caldwell Ida.

15. Filed Dec. 30 1920 John L. Meyer Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 24 1920 to Dec 29 1920
that I last saw h.... alive on Dec 28 1920
and that death occurred on the date stated above, at 2 A. M.
The CAUSE OF DEATH* was as follows:
Chronic Nephritis
(Duration) Several years Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) [illegible] M. D.
12/29 1920 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill — DATE OF BURIAL: 12-31 1920

20. UNDERTAKER: C. T. Peckham — ADDRESS: Caldwell, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH (9)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of Caldwell

Registration District No. 9

Primary Registration District No. 2002 (2005)

(No. ..... St.)

File No. 32530

Registered No. 134

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Selina Biggs

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: July (Month) 22 (Day) 1914 (Year)

7. AGE: 6 Yrs. 5 Mos. 8 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER: Grover W Biggs

11. BIRTHPLACE OF FATHER (State or Country) Ind

12. MAIDEN NAME OF MOTHER: Alice Montague

13. BIRTHPLACE OF MOTHER (State or Country) S Dacota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G W Biggs

(Address) Nampa Ida

15. Filed Dec. 30, 1920 John C Meyer, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 1920 to Dec 30 1920 that I last saw h.. alive on Dec 29 1920 and that death occurred on the date stated above, at 9 M.

The CAUSE OF DEATH* was as follows:

Heart Trouble

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J M Cole M. D.

12/30 1920 (Address) Caldwell, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill

DATE OF BURIAL: Dec 31 1920

20. UNDERTAKER: CASE FURNITURE CO.

ADDRESS: Caldwell

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Canyon

City of

(No. , St.)

Registration District No. 7

Primary Registration District No. 2004

File No. 32534

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maggie Catherine Davis

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 26 (Day) 1858 (Year)

7. AGE: 62 Yrs. Mos. ds.

IF LESS than 1 day, how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J. S. James

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: Eliza Davis

13. BIRTHPLACE OF MOTHER (State or Country): Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Davis

(Address) Nampa Ida

15. Filed Jan 10 1921 R.T.D. Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920, to Dec 24 1920, that I last saw h[er] alive on Dec 20 1920, and that death occurred on the date stated above, at 7 a. M.

The CAUSE OF DEATH* was as follows:

Pernicious anemia

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Myocarditis

(Duration) yrs. 3 mos. ds.

(Signed) M. H. Tallman M. D.

12/27 1920. (Address) Boise Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boise Valley Cemetery

DATE OF BURIAL: 12/28 1920

20. UNDERTAKER: F K Robinson

ADDRESS: Nampa

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32535
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7
Primary Registration District No. 1056
(No. 617 — 9th Ave So St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Earl Donald Rose

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	

6. DATE OF BIRTH: Aug (Month) 30 (Day) 1 (Year)

7. AGE: Yrs. 4 Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER D. A. Rose

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Stella Clark

13. BIRTHPLACE OF MOTHER (State or Country) Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. A. Rose
(Address) Nampa Ida

15. Filed Ja 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 25. 1920 to Dec. 25. 1920 that I last saw him alive on Dead upon arrival. and that death occurred on the date stated above, at 12- M.

The CAUSE OF DEATH* was as follows:
Acute enteritis.

(Duration) Yrs. mos. 1- ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) D. B. Smith M. D.
1/8 1921 (Address) Nampa Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	1/2/21 1920
20. UNDERTAKER F R Robinson	ADDRESS Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32538

Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1006

(No. 414 16th Ave S St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Evelyn Rae Blinn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	

6. DATE OF BIRTH: Apr (Month) 8 (Day) 1912 (Year)

7. AGE: Yrs. 8 Mos. 20 ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: G H Blinn

11. BIRTHPLACE OF FATHER (State or Country): Oregon

12. MAIDEN NAME OF MOTHER: Mayme Swarty

13. BIRTHPLACE OF MOTHER (State or Country): Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs GH Blinn

(Address) Nampa

15. Filed Jan 10 1920 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/21 1920 to 12/28 1920 that I last saw her alive on 12/27 1920 and that death occurred on the date stated above, at 8 A. M.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(Duration) — Yrs. — mos. — ds.

Contributory (Secondary) Acute Gastro Enteritis

(Duration) — yrs. — mos. 3 ds.

(Signed) Leo W Chilton M. D.

19 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Nampa Ida	12 30 1920
20. UNDERTAKER	ADDRESS
F H Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

C

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32539

Registered No.

Registration District No. 7

Primary Registration District No. 102

1. PLACE OF DEATH

County of Canyon

City of Nampa

(No. Mercy Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edmund James Purves

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	Single

6. DATE OF BIRTH: Jan (Month) 9 (Day) 1904 (Year)

7. AGE: 16 Yrs. 11 Mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: In school
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: J. M. Purves

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Myrtle Del Booher

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. M. Purves
(Address) Nampa Ida

15. Filed Jan 10 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1920, to Dec 14 1920, that I last saw him alive on Dec 14 1920 and that death occurred on the date stated above, at 4 A.M.

The CAUSE OF DEATH* was as follows:

Septicaemia following injury to knee.
Pneumonia followed.

(Duration) ..... Yrs. ..... mos. 9 ds.

Contributory (Secondary) Appendicitis

(Duration) ..... yrs. ..... mos. one ds.

(Signed) Horace P Belknap M. D.

12/14 1920 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 28 days

Where was disease contracted if not at place of death? Nampa Ida

Former or usual residence Nampa Ida.

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 12-17 1920

20. UNDERTAKER: F K Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1004
File No. 32540
Registered No.

1. PLACE OF DEATH

County of Canyon
City of Nampa
(No. 423 - 5th Ave So St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Valentine

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	

6. DATE OF BIRTH Dec (Month) 23 (Day) 1920 (Year)

7. AGE ~ Yrs. Mos. ds.

IF LESS than 1 day how many 1 hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ~

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER L. W. Valentine

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Bertha Sowder

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. W. Valentine

(Address) Nampa Ida

15. Filed Jan 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/23 1920, to 12/23 1920 that I last saw him alive on 12/23 1920 and that death occurred on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Premature infant, Tmas

(Duration) Yrs. mos. 1 hours ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Leo W Chilton M. D.

19 (Address) Nampa Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Catholic Cem	12/24 1920

20. UNDERTAKER	ADDRESS
J. K. Robinson	Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 32541
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No. 1511 1st S St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lilly A Hamilton
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Sep (Month) 3 (Day) 1870 (Year)

7. AGE: 50 Yrs. 3 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: John Widiamson

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. B. Hamilton
(Address) Nampa Ida

15. Filed Jan 10 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1920, to Dec-11th 1920
that I last saw h[illegible] alive on Dec-11 1920
and that death occurred on the date stated above, at 1-15 M.

The CAUSE OF DEATH* was as follows: Gastric Carcinoma

(Duration) 1 Yrs. — mos. — ds.

Contributory (Secondary)

(Duration) 1 yrs. — mos. — ds.

(Signed) F. B. Smith M. D.

12/16 1920 (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 12/14 1920

20. UNDERTAKER: F. A. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

Smith

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 32542
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No Mercy Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beatrice A. Johnson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Dec (Month) 8 (Day) 1901 (Year)

7. AGE: — Yrs. — Mos. 3 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Devon Johnson

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Clara Hiatt

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Baum
(Address)

15. Filed Jan 13 1921 Pearle Dodds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-8 1920, to 12-11 1920, that I last saw her alive on 12-10 1920, and that death occurred on the date stated above, at 3. P.M.

The CAUSE OF DEATH* was as follows:
Pharyngeal hemorrhage
(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Hemophilia
(Duration) yrs. mos. ds.

(Signed) H C Robinson M. D.
19 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 12-11 1920

20. UNDERTAKER: None — ADDRESS: —

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 1006
File No. 32513
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Nampa
(No Mercy Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frank W. Kirkbride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Dec (Month) 7 (Day) 1920 (Year)

7. AGE: Yrs. 2 Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: C
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jos Kirkbride

11. BIRTHPLACE OF FATHER (State or Country): Colo

12. MAIDEN NAME OF MOTHER: Helen Carter

13. BIRTHPLACE OF MOTHER (State or Country): Nebr

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jos Kirkbride
(Address) Nampa, Ida

15. Filed Dec 16 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9th 1920, to Dec 10 1920, that I last saw him alive on Dec 10 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Marion J. Finck M. D.
19..... (Address) Nampa Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 12-11 1920

20. UNDERTAKER: Fred L Robinson — ADDRESS: Nampa

Fink

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32544
Registered No.

1. PLACE OF DEATH

County of Canyon

City of Nampa

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 7

Primary Registration District No. 1506

(No. Mercy Hospital St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Thomas Miller

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1863 (Year)

7. AGE: 57 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Miner

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: Miller

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: England

13. BIRTHPLACE OF MOTHER (State or Country): .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Dec 10 1920 Pearle Dodds Local Registrar

GYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920 to Dec 10 1920 that I last saw h.. alive on Dec 10 1920 and that death occurred on the date stated above, at 2 M.

The CAUSE OF DEATH* was as follows: Pulmonary tuberculosis

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

Dec 11 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Nampa Ida — DATE OF BURIAL: 12-16 1920

20. UNDERTAKER: F. K. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 47

Primary Registration District No. 2196

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32546
Registered No. 4747

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James W. Bridges

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 25 (Day) 1864 (Year)

7. AGE: 58 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Transfer & Storage
(b) General nature of industry, business, or establishment in which employed (or employer): Business

9. BIRTHPLACE (State or Country): Ft. Indiana

10. NAME OF FATHER: James W. Bridges Sr.

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Margaret Russell

13. BIRTHPLACE OF MOTHER (State or Country): Unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Dec. 18 — 1917 — D. C. Patterson, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 14 (Day) 1917 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 14 1920 to Nov. 14 1920 that I last saw h alive on Nov. 14 1920 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
Chronic

(Duration) 5 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration) — Yrs. — mos. — ds.

(Signed) L. L. Hoopes M. D.

11/18-1920 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley, Ida — DATE OF BURIAL: 11-21-1920

20. UNDERTAKER: L. B. Walkley — ADDRESS: Burley, Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32547
Registered No. 760

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry N. Beckendorf

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: April (Month) 4 (Day) 1887 (Year)

7. AGE: 33 Yrs. 7 Mos. 4 ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebr.

10. NAME OF FATHER: William C. Beckendorf

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Sarah Minett

13. BIRTHPLACE OF MOTHER (State or Country): Wisc.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Royce W. Beckendorf
(Address) R.F.D. #1 Heyburn

15. Filed Nov. 10 1920 W. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Electrocuted by high tension wire.
accidental
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary)
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) L.B. Talloghy Coroner M. D.
Nov. 10 1920. (Address) Burley Ida.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fairmont Nebr. DATE OF BURIAL: Nov. 15 1920

20. UNDERTAKER: L.B. Talloghy ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH 7

Registration District No. 11

Primary Registration District No. 2196

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32548
Registered No. 761

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Darling Lowell Gardner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Feb. 23 (Month) (Day) 1920 (Year)

7. AGE: ....Yrs....Mos....ds. IF LESS than 1 day how many ... hrs. or ...min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Burley Ida.

10. NAME OF FATHER: William M. Gardner

11. BIRTHPLACE OF FATHER (State or Country): Missouri Kansas

12. MAIDEN NAME OF MOTHER: Edith Workman

13. BIRTHPLACE OF MOTHER (State or Country): Nevada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm. M. Gardner
(Address) Burley Ida.

15. Filed 12-15- 1920 Dr. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 17. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1920 to Nov. 17 1920 that I last saw h-m alive on Nov. 1920 and that death occurred on the date stated above, at 11:30 P.M.

The CAUSE OF DEATH* was as follows:
Septicaemia following
abortion

(Duration) .... Yrs. 1 mos. .... ds.

Contributory (Secondary)

(Duration) .... Yrs. .... mos. .... ds.

(Signed) J. C. Patterson M. D.
11-18 1920 (Address) Burley, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: 11/19/ 1920

20. UNDERTAKER: L. B. Gallagher ADDRESS: Burley Ida.

Patterson

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3549
Registered No. 762

Registration District No. 111
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Viola Bartlett

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. June (Month) 18 (Day) 1 (Year)

7. AGE: 32 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill.

10. NAME OF FATHER: George W. Brown.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Mary Davis.

13. BIRTHPLACE OF MOTHER (State or Country): Ill.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Bartlett
(Address) Box 83 = Burley Ida.

15. Filed 12-13- 1920 W. J. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 19. (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1920 to Nov 19 1920.
that I last saw her alive on Nov 19 1920.
and that death occurred on the date stated above, at 10:45 A.M.

The CAUSE OF DEATH* was as follows:
Tuberculosis of Lungs
.....
.....
.....
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. E. Patterson M. D.
11-20 1920. (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: Nov. 20. 1920

20. UNDERTAKER: L. B. Talbot ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32550
Registered No. 2262

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 111
Primary Registration District No. 2196
(No. ....., ... St.)

2. FULL NAME Delbert E. Sayley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 21 (Day) 1919 (Year)

7. AGE: 1 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Chas. W. Sayley

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Carrie Sanders

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. W. Sayley
(Address) Burley Idaho R.F.D.

15. Filed 12-15- 1920 P. J. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 31st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct. 7 1920 to Oct. 30 1920 that I last saw him alive on Oct. 30 1920 and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Pseudo Diphtheria
(Duration) Yrs. mos. 10 ds.
Contributory (Secondary): Paralysis
(Duration) Yrs. mos. 3 ds.

(Signed) R. J. Stacy M. D.
11/11 1920 (Address) Burley Idaho

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL ..... 191...

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Patterson.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32551
Registered No. 7622

1. PLACE OF DEATH
County of Cassia
City of Albion
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 21-96
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Verna E. Clark

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH. May (Month) 18 (Day) 1 (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Albion Ida.

10. NAME OF FATHER James L. Clark

11. BIRTHPLACE OF FATHER (State or Country) Albion Ida.

12. MAIDEN NAME OF MOTHER Lillie Mary [illegible]

13. BIRTHPLACE OF MOTHER (State or Country) Malta Ida.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. L. Clark
(Address) Albion Idaho

15. Filed 12-18 1920. W. J. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 27 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 24 1920 to Nov 27 1920
that I last saw h.. alive on Nov 24 1920.
and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:
Empyema
(Duration) ..... Yrs. ..... mos. 7 ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) J. C. Patterson M. D.
11-29 1920. (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Albion Idaho. DATE OF BURIAL Nov. 28. 1920

20. UNDERTAKER L. D. Scoggy. ADDRESS Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 117
Primary Registration District No. 2196
File No. 32552
Registered No. 273

1. PLACE OF DEATH.
County of Cassia
City of Oakley
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Francisco Seliate

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Divorced
6. DATE OF BIRTH. January (Month) 13 (Day) 1883 (Year)
7. AGE: 37 Yrs. 11 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Spain
10. NAME OF FATHER: Not Obtainable
11. BIRTHPLACE OF FATHER (State or Country): Not obtainable
12. MAIDEN NAME OF MOTHER: Not Obtainable
13. BIRTHPLACE OF MOTHER (State or Country): Not obtainable
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jose L Ramos
(Address) Oakley Idaho
15. Filed 12-24-1920 Mrs. J. C. Patterson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 21 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1920, to Dec 21 1920, that I last saw him alive on Dec 21 1920, and that death occured on the date stated above, at 10-20 P M.
The CAUSE OF DEATH* was as follows:
Accidental injury to Chest
(Duration) ..... Yrs. ..... mos. 11 ds.
Contributory (Secondary) Lobar pneumonia
(Duration) ..... yrs. ..... mos. 5 ds.
(Signed) Jose L Ramos M. D.
12/22/1920 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Burley Ida. DATE OF BURIAL: 12/24/1920
20. UNDERTAKER: L. L. Galloway ADDRESS: Burley Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BKBS. 24658

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 11

Primary Registration District No. 2196

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32253
Registered No. 7247

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Cassia

City of Burley

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bert O. McCulloch

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word)
M	White	D

6. DATE OF BIRTH. Oct (Month) 17 (Day) 1920 (Year)

7. AGE ..... Yrs. 2 Mos. 3 ds.

IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER B. O. McCulloch

11. BIRTHPLACE OF FATHER (State or Country) Logan Utah

12. MAIDEN NAME OF MOTHER Maude Maughan

13. BIRTHPLACE OF MOTHER (State or Country) Logan Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) B. O. McCulloch

(Address) Burley Ida

15. Filed 12-21-1920 W. J. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from October 17 1920 to Dec 20 1920 that I last saw him alive on Dec 20 1920 and that death occurred on the date stated above, at 6:15 M.

The CAUSE OF DEATH* was as follows:

Postero Basic Meningitis

(Duration) 2 Yrs. mos. 4 ds.

Contributory (Secondary) Toxic Gastro-Enteritis

(Duration) 2 Yrs. 1 mos. 10 ds.

(Signed) S. K. Smith M. D.

12/20/1920 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Logan Utah

DATE OF BURIAL 12/22/1920

20. UNDERTAKER R. V. Watt

ADDRESS Burley Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32554
Registered No. 468

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dick Cooper Pitton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	White	Single

6. DATE OF BIRTH. May (Month) 13 (Day) 1913 (Year)

7. AGE 7 Yrs. 6 Mos. 24 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J C Pitton Jr

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Julia Dean Wardell

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J C Pitton Jr
(Address) Burley Ida

15. Filed 12-8-20 191.... Local Registrar. J. C. Patterson

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4 1920 to Dec. 7 1920 that I last saw him alive on Dec. 7 1920: and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
Diphtheria
.....
.....
.....(Duration) ..... Yrs..... mos. 8 ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
12-8 1920. (Address) Burley, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Pleasant Hill Cemetery — DATE OF BURIAL 12/8 1920.

20. UNDERTAKER Rinewalt — ADDRESS Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2196
File No. 595
Registered No. 469

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(No. 60 Overland St.)

2. FULL NAME Frank Leslie Boner

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 19 (Day) 1885 (Year)

7. AGE: 35 Yrs. 6 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Live Stock Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Kansas.

10. NAME OF FATHER Thomas N. Boner

11. BIRTHPLACE OF FATHER
(State or Country) Ohio.

12. MAIDEN NAME OF MOTHER Fannie H Marsh

13. BIRTHPLACE OF MOTHER
(State or Country) England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Myrtle Boner
(Address) Burley Idaho

15.
Filed Dec. 16 1920
Dr. J. C. Cathro
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191... to ..... 191...
that I last saw h...alive on ..... 191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning.

..... (Duration) ..... Yrs..... mos..... ds.

Contributory (Secondary) .....
..... (Duration) ..... Yrs..... mos..... ds.

(Signed) L. B. Talloggy — Coroner — ~~M. D.~~
Dec 15 1920. (Address) Burley Ida.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burley Ida.
DATE OF BURIAL: Dec. 16. 1920

20. UNDERTAKER: L. B. Talloggy.
ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

Transcribed

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32556

Registered No. 470

Registration District No. 11

Primary Registration District No. 2196

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley

2. FULL NAME John R. Abbott

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. Aug. 10 1840
(Month) (Day) (Year)

7. AGE: 80 Yrs. 4 Mos. 5 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Stock Grower
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Penn.

10. NAME OF FATHER: Daniel Abbott

11. BIRTHPLACE OF FATHER
(State or Country) England.

12. MAIDEN NAME OF MOTHER: Elsie Rook

13. BIRTHPLACE OF MOTHER
(State or Country) Penn.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) D. W. Abbott
(Address) Declo Ida.

15.
Filed Dec 17 1920 W. J. Patten
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 8 1911 to Dec 15 1920
that I last saw him alive on Aug 6 1920
and that death occurred on the date stated above, at 10. P.M.

The CAUSE OF DEATH* was as follows:

Dilation of Heart

(Duration) 2 Yrs. mos. ds.

Contributory (Secondary) Old age

(Duration) Yrs. mos. ds.

(Signed) R. W. Abbott M. D.

19 (Address) Declo Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Declo Ida. DATE OF BURIAL: 12/16/ 1920

20. UNDERTAKER ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 11
Primary Registration District No. 2196
File No. 32557
Registered No. 4757

1. PLACE OF DEATH
County of Cassia
City of Oakley
If death occurs away from usual residence, give facts called for under special information.

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John J. Kolins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Single

6. DATE OF BIRTH. About 47 1 .....
(Month) (Day) (Year)

7. AGE ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Bohemia

10. NAME OF FATHER Unknown

11. BIRTHPLACE OF FATHER
(State or Country) "

12. MAIDEN NAME OF MOTHER "

13. BIRTHPLACE OF MOTHER
(State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Employment Card
(Address) on Record

15.
Filed Dec 24 1920 Wm J Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov 28 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
..... Pneumonia
.....
.....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) L. B. Gallogly M. D.
12/24/1920 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Burley Ida. — DATE OF BURIAL Dec 29. 1920

20. UNDERTAKER L. B. Gallogly — ADDRESS Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32558
Registered No. 492

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2196
(No. 127 So. Almo Ave. St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lulu Mathes

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. Feb. (Month) 21 (Day) 1878 (Year)

7. AGE 42 Yrs. 9 Mos. 28 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Missouri

10. NAME OF FATHER George Thompson

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Martha Rooks

13. BIRTHPLACE OF MOTHER (State or Country) Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Roy Mathes
(Address) 127 So. Almo Burley Ida.

15. Filed 12-27- 1920 Dr. J. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1920 to Dec 19 1920 that I last saw her alive on Dec 19 1920 and that death occurred on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs..... mos. 8 ds.

(Signed) J. L. Patterson M. D.
12-27 1920 (Address) Burley Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the ,State....yrs....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls Ida.	Dec. 22 1920
20. UNDERTAKER	**ADDRESS**
L. B. Gallogly	Burley Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

Utah

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32559
Registered No. 1752

Registration District No. 11
Primary Registration District No. 2196

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Druscilla Dorothy Louden

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May 15 1895 (Month) (Day) (Year)

7. AGE: 25 Yrs. 6 Mos. ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John W. Richardson

11. BIRTHPLACE OF FATHER (State or Country): Eng

12. MAIDEN NAME OF MOTHER: Maria D Anderson

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): D. Louden
(Address): Burley R. 3

15. Filed Jan 4 1921 Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 2 1920 to Sept 13 1920
that I last saw her alive on Sept 12 1920
and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:
Phlegmatia alba dolens
(Duration) Yrs. mos. 11 ds.
Contributory (Secondary) Childbirth
(Duration) Yrs. mos. ds.

(Signed) R. T. Terry M. D.
Oct 5 1920 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Reeds Cemetery — DATE OF BURIAL: Sept 15 1920

20. UNDERTAKER: Ellsworth — ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32560
Registered No. 476

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 11
Primary Registration District No. 2196
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Willard Andrew Kuhn

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 5 (Day) 1886 (Year)

7. AGE: 34 Yrs. 4 Mos. 4 ds. IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Nebr

10. NAME OF FATHER: Emory Kuhn

11. BIRTHPLACE OF FATHER (State or Country): Ills

12. MAIDEN NAME OF MOTHER: Matilda Krueger

13. BIRTHPLACE OF MOTHER (State or Country): Ills

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Dec. 14 1920 Hugh E. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191.... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Accidental Drowning
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) L. B. Talbot by F. Cooner M. D.
12/30/1920, (Address) Burley Ida.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means of Injury and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Riverside Hill Cemetery — DATE OF BURIAL: 12/13 1920

20. UNDERTAKER: Robert W Watt — ADDRESS: Burley Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32561
Registered No. [illegible]

1. PLACE OF DEATH
County of Cassia
City of Declo
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

2. FULL NAME Vessa N. Simmons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: June (Month) 13 (Day) 1884 (Year)
7. AGE: 36 Yrs. 6 Mos. 17 ds. IF LESS than 1 day how many .... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Utah
10. NAME OF FATHER: George W. Nebeker
11. BIRTHPLACE OF FATHER (State or Country): Utah
12. MAIDEN NAME OF MOTHER: Melissa Howe
13. BIRTHPLACE OF MOTHER (State or Country): Utah
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John E. Simmons
(Address) Declo Idaho
15. Filed Jan 3 1921 Wm J. C. Parkinson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 30 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1920 to Dec 30 1920
that I last saw her alive on Dec 30 1920
and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. 0 mos. 3 ds.

Contributory (Secondary) Chronic Nephritis Valvular Heart Disease

(Duration) 4 Yrs. ..... mos. ..... ds.

(Signed) G. P. Smith M. D.
12/31 1920 (Address) Burley Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the ,State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Richfield Utah
DATE OF BURIAL: Jan 3 1921
20. UNDERTAKER: L. B. Talboy
ADDRESS: Burley Ida

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32562
Registered No. 439

Registration District No. 117
Primary Registration District No. 2196

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME F. A. Kasser

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. ..... Unknown ..... 1 .....
(Month) (Day) (Year)
7. AGE about 55 years
.....Yrs.....Mos.....ds.
IF LESS than 1 day how many .... hrs. or .....min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer) .....
9. BIRTHPLACE
(State or Country) Ill.
10. NAME OF FATHER: Unknown
11. BIRTHPLACE OF FATHER
(State or Country) " "
12. MAIDEN NAME OF MOTHER: "
13. BIRTHPLACE OF MOTHER
(State or Country) "
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. B. Galloghy
(Address) Burley Ida.
15.
Filed 12-15 1920
Dr. J. C. Patterson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
..... Dec. 13 1920
(Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from
..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at 9.30 P. M.
The CAUSE OF DEATH* was as follows:
Stomach Poisoning
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory .....
(Secondary)
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) L. B. Galloghy Coroner M. D.
.....19.... (Address) .....
*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elgin Ill.
DATE OF BURIAL ..... 191...
20. UNDERTAKER: L. B. Galloghy
ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32563
Registered No. 466

Registration District No. 117
Primary Registration District No. 2196
(No. ....., ... St.)

1. PLACE OF DEATH
County of Cassia
City of Burley
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louisa Coltrin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. (Month) (Day) (Year): 1853

7. AGE: 67 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: "

11. BIRTHPLACE OF FATHER (State or Country): "

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ether L. Coltrin
(Address) Burley Ida.

15. Filed 12-18 1920 Dr. J. C. Pattison Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:
General Debility

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) L. B. Talloggy Coroner M. D.
12/17/1920 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Woodcrose Utah — DATE OF BURIAL: Dec. 19 1920

20. UNDERTAKER: L. B. Talloggy — ADDRESS: Burley Ida.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32564
Registered No. 477

Registration District No. 117
Primary Registration District No. 21.96
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Cassia
City of Burley

2. FULL NAME Velma A. Wheeler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Jan. (Month) 12 (Day) 1920 (Year)

7. AGE: 1 Yrs. 11 Mos. 19 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Arthur Wheeler

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Alice Anna Stephens

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Wheeler
(Address) Burley Idaho

15. Filed 12-31 1920 H. D. C. Patterson Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1920 to Dec 30 1920
that I last saw h..... alive on ..... 191....
and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Diphtheria

(Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. C. Patterson M. D.
12-31 1920 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Leiriston Utah (Via Trenton) — DATE OF BURIAL: 1/1/21 191...

20. UNDERTAKER: L. D. Gallogly — ADDRESS: Burley Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32565
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. 119
Primary Registration District No. 2198
(No. ..... St.)

1. PLACE OF DEATH
County of Cassia
City of Malta
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah A. Semble

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 28 (Day) 1847 (Year)

7. AGE: 73 Yrs. # Mos. 9 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) St Louis, Mo.

10. NAME OF FATHER Samuel Cotterell

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. D. L. Beecher
(Address) Conant Idaho

15. Filed Dec 12 1920 — C. I. Sater, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1920 to Dec 7 1920 that I last saw h[illegible] alive on Dec. 7 1920 and that death occurred on the date stated above, at 11:15 A.M.

The CAUSE OF DEATH* was as follows:
Hemiplegia
(Duration) ..... Yrs. ..... mos. 14 ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) C. I. Sater M. D.
12/12 1920 (Address) Malta Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 40 yrs. ... mos. ... days. In the State 40 yrs. ... mos. ... days
Where was disease contracted if not at place of death? at place of death
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Albion Idaho — DATE OF BURIAL 12/11/20

20. UNDERTAKER: L. B. Scaggs — ADDRESS: Burley Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

32566

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 2/94
File No. X44
Registered No. 7

1. PLACE OF DEATH.
County of Cassia
City of Oakley
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah Rebecca Bowles

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 12 (Day) 1851 (Year)

7. AGE: 69 Yrs. 6 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Tazewell County Virginia

10. NAME OF FATHER: William Clark

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Elizabeth Litz

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) H. E. Bowles
(Address) Oakley, Idaho

15. Filed Jan 10 19 21 — Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 17 1920, to Dec. 4 1920, that I last saw her alive on Dec. 4 1920, and that death occured on the date stated above, at 6:20 P.M.

The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) Broncho-pneumonia
(Duration) ..... yrs. ..... mos. 7 ds.
(Signed) Jesse L. Rains M. D.
Dec 6 1920 (Address) Oakley Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Oakley Idaho — DATE OF BURIAL: Dec 6 1920

20. UNDERTAKER: [signature] — ADDRESS: Oakley Idaho

STEAM - YORK CO., PTRS. & RUBR. 24053

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

32567

[redacted] of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 120
Primary Registration District No. 2195
File No. XVII
Registered No. 8

1. PLACE OF DEATH.
County of Cassia
City of Oakley
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Margaret Jones

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Sept 25 1857 (Month) (Day) (Year)

7. AGE: 64 Yrs. 3 Mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wales

10. NAME OF FATHER: James Davis

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary Davis

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Jones
(Address) Burley Idaho Rt 2

15. Filed Jan 15 1927 A. J. Nash Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1926 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 26 1926, to Dec 27 1926, that I last saw h[illegible] alive on Dec 26 1926, and that death occured on the date stated above, at 12 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

12/29 1926 (Signed) A. J. Nash M. D.
(Address) Oakley, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Marion — DATE OF BURIAL: Dec 29 1926

20. UNDERTAKER: J. P. Gaussey — ADDRESS: Oakley Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & SOBS. 24658

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Clearwater
City of Orofino, Idaho (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 10
Primary Registration District No. 2168

File No. 32568
Registered No. 56
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Peter Sherlock.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Widower

6. DATE OF BIRTH
June 1st 1838
(Month) (Day) (Year)

7. AGE
82 yrs. 6 mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or dstablishment in which employed (or employer): Mining

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER ?

11. BIRTHPLACE OF FATHER (State or Country) ?

12. MAIDEN NAME OF MOTHER ?

13. BIRTHPLACE OF MOTHER (State or Country) ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Atteberry
(Address) Orofino, Idaho

15.
Filed Jany 1924 [signature illegible]
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
December 5th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb. 23 1919, to Dec. 5th 1920
that I last saw h[illegible] alive on Dec. 5th 1920
and that death occurred on the date stated above, at 7:15 P.M.
The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
?
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Insanity
?
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. Kenneth Greene, M. D.
12/6 1920 (Address) Orofino, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. 9 mos. 14 days. In the State over 50 years .....yrs. .....mos. .....days.
Where was disease contracted if not at place of death? ?
Former or usual residence Wallace, Idaho.

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sanitarium Cemetery	12/8 1920

20. UNDERTAKER	ADDRESS
J. W. Atteberry	Orofino Ida.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 90
Primary Registration District No. 2168
File No. 32569
Registered No.

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Daniel S Harper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: July (Month) 8 (Day) 1920 (Year)

7. AGE: Yrs. √ Mos. 9 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: S F. Harper

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Mary Delaney

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Delaney
(Address) Caldwell Idaho

15. Filed Dec 17 1920 — M. Mc Fairley, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 17th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10th 1920, to Dec 17th 1920, that I last saw h[illegible] alive on Dec 17th 1920, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) Yrs. mos. 20 ds.

Contributory (Secondary): Pneumonia

(Duration) yrs. 3 mos. ds.

(Signed) F. M. Fairley M. D.

Dec 17 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida — DATE OF BURIAL: Dec 19 1920

20. UNDERTAKER: C. E. Babb & Son — ADDRESS: Caldwell Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH — Registration District No. 90
County of Clearwater — Primary Registration District No. 2168
City of Lenora — (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. 32570
Registered No. 98

2. FULL NAME A. L. Garrison

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	married

6. DATE OF BIRTH ..... 1..... (Month) (Day) (Year)

7. AGE 53 Yrs. ..... Mos. ..... ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Ill.

10. NAME OF FATHER Garrison

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ray Garrison
(Address) Lenora Idaho

15. Filed Dec 21 19 20 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 20 (Day) 19 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 2 00 M.
The CAUSE OF DEATH* was as follows: Tree fell on head causing instant death.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. W. Horswell M. D.
Dec 21 19 20 (Address) Orofino Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL — DATE OF BURIAL
Teaken Idaho Dec 23 20

20. UNDERTAKER — ADDRESS
L. C. Cann Lenora

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 2168
File No. 32571
Registered No.

1. PLACE OF DEATH
County of Clearwater
City of Orofino
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph J. Tautoni

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Jan 1 1854 (Month) (Day) (Year)

7. AGE: 66 Yrs. 11 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Jacob Tautoni

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Joseph J Tautoni
(Address) Orofino Idaho

15. Filed Dec 29 1920 H. M. Family
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 29 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from about Dec 15 1920 to Dec 29 1920
that I last saw h. alive on Dec 28 1920
and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Cancer of Pancreas
not known
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earle M Hansen M. D.
Dec 30 1920 (Address) Orofino Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Orofino Idaho — DATE OF BURIAL 1920

20. UNDERTAKER: Vasko and Son — ADDRESS: Orofino

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32572

Registered No. 61

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Canyon

City of Caldwell (No. / St.)

Registration District No. 90

Primary Registration District No. 2168

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Unnamed

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 19 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 5 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: -
(b) General nature of industry business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: U. G. Warden

11. BIRTHPLACE OF FATHER (State or Country): Kans.

12. MAIDEN NAME OF MOTHER: Minerva Canaan

13. BIRTHPLACE OF MOTHER (State or Country): Miss.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) U. G. Warden
(Address) Caldwell, Ida.

15.
Filed Dec 25 1920 J. M. Daily
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 1920, to Dec 24 1920, that I last saw h[illegible] alive on Dec 23 1920, and that death occurred on the date stated above, at 9:00 A. M.

The CAUSE OF DEATH* was as follows:

Transitory Convulsions
Jaundice Cause unknown

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) Prematurity

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Daily M. D.

12/25 1920 (Address) Caldwell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State. ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Caldwell Ida — DATE OF BURIAL: 12/27 1920

20. UNDERTAKER: Crane — ADDRESS: -

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

BYMS - YORK CO., PTRS. & BDRS. 18760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32573
Registered No. 60

1. PLACE OF DEATH
County of Canyon
City of Caldwell
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 90
Primary Registration District No. 2168

2. FULL NAME Albert Lee Harper

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	

6. DATE OF BIRTH July (Month) 8 (Day) 1920 (Year)

7. AGE 5 Yrs. 22 Mos. ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER S. J. Harper

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Mary Delaney

13. BIRTHPLACE OF MOTHER (State or Country) Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary Delaney
(Address) Caldwell Idaho

15. Filed Dec 30 1920 J. W. Finch Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10, 1920, to Dec 30 1920, that I last saw h... alive on Dec 30 1920, and that death occurred on the date stated above, at 8:00 A.M.
The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) ..... Yrs. ..... mos. 20 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Finch M. D.
Dec 30 1920 (Address) Caldwell Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Caldwell Idaho	Dec 31 1920

20. UNDERTAKER Caldwell Und Co ADDRESS Caldwell Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 125
Primary Registration District No. 2203
File No. 32574
Registered No.

1. PLACE OF DEATH.
County of Clark
City of Dubois
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha E Ellis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: July (Month) 6 (Day) 1864 (Year)

7. AGE: 57 yrs. 4 mos. 29 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virginia

10. NAME OF FATHER: E F Smith

11. BIRTHPLACE OF FATHER (State or Country): North Carolina

12. MAIDEN NAME OF MOTHER: Jane Davis

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Kyle Pugh
(Address) Irish Trap Mont

15. Filed Dec. 6 1920 C E Jones M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
12 (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 27 1920, to Dec. 2, 1920, that I last saw her alive on Dec. 2, 1920 and that death occurred on the date stated above, at 7 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia at first, but She recovered from this and Inflamatory Rheumatism

(Duration) yrs. mos. 11 ds.

Contributory (Secondary) Inflamatory Rheumatism & Kidney affection

(Duration) yrs. mos. ds.

(Signed) A Howard Garrett M.D.
1/6 1920 (Address) Dubois Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Dubois Idaho | DATE OF BURIAL: 12/8 1920

20. UNDERTAKER: Clifford E Hayes | ADDRESS: Idaho Falls Idaho

SYMS - YORK CO., PTRS. & BDRS. 1976O

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
File No. 32575
Registered No.

1. PLACE OF DEATH
County of Custer
City of Mackay
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Verdie Dell White.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write word.): Single

6. DATE OF BIRTH: Sept (Month) 11 (Day) 1906 (Year)

7. AGE: 14 Yrs. 3 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School girl.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Alexander White.

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Emily A Fox.

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Emily A. White
(Address) Mackay - Ida.

15. Filed 1/3 1921 Roe Mowatt
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1920, to Dec 29 1920, that I last saw h[er] alive on Dec 29 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial).

(Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) M. E. Farrell, M. D.

12/30 1920 (Address) Mackay Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt. McCaleb Cemetery
DATE OF BURIAL: 1/1 1921

20. UNDERTAKER
ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
(No. ..... St.)

File No. 20577
Registered No. 2577

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maxene May Walker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	single

6. DATE OF BIRTH: Feb. (Month) 14th (Day) 1918 (Year)

7. AGE: 2 Yrs. 7 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Mountain Home Ida

10. NAME OF FATHER Eugene L. Walker

11. BIRTHPLACE OF FATHER (State or Country) Idaho

12. MAIDEN NAME OF MOTHER Lulu Corder-

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Anna M. Walker
(Address) Mountain Home, Idaho

15. Filed 9/21 1920 J E Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 19th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 5:45 P.M.
The CAUSE OF DEATH* was as follows:
Struck by pilot of engine #3133 while sitting on track Train #16
Instant (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Skull fractured
Instant (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H. H. Eaton Coroner M. D.
9/19 1920 (Address) Mtn Home, Ida Calmore

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Burial, Idaho	9/21 1920

20. UNDERTAKER	ADDRESS
A. W. Conover	Mtn Home

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 32578
Registered No. 28

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Bridgewood
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 29 (Day) 1847 (Year)

7. AGE: 73 Yrs. 10 Mos. 13 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Robert Whittle

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sophia Dory

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. H. Bridgewood
(Address) Mtn Home Ida

15. Filed 12-31-1920
J. E. Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to 12-12-1920, that I last saw h[illegible] alive on 12-11-1920, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of Stomach
..... (Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. E. Evans M. D.
12-20-1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home, Ida; DATE OF BURIAL: 12-14-1920

20. UNDERTAKER: A. R. Conover ADDRESS: Mtn Home Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 32579
Registered No. 29

1. PLACE OF DEATH

County of Elmore
City of Mtn Home
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary R. Wheeler

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED Married (Write the word.)

6. DATE OF BIRTH May (Month) 13 (Day) 1884 (Year)

7. AGE 36 Yrs. 7 Mos. 10 ds.

IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Thomas Wayte

11. BIRTHPLACE OF FATHER (State or Country) N. Y.

12. MAIDEN NAME OF MOTHER Elizabeth -

13. BIRTHPLACE OF MOTHER (State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) C. F. Wheeler

(Address) Mtn Home Ida.

15. Filed 12-31 1920

J. E. Conover
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 23 (Day) – 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-23-1920, to 12-23-1920 that I last saw her alive on 12-23-1920, and that death occurred on the date stated above, at 6:45 P.M.

The CAUSE OF DEATH* was as follows: Pyosalpinx, with Rupture

.....(Duration) .....Yrs. .....mos. ½ ds.

Contributory (Secondary) Chronic Salpingitis

.....(Duration) 6 yrs. .....mos. .....ds.

(Signed) .....M. D.

12-24-1920 (Address) Mtn Home Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Mtn Home Ida

DATE OF BURIAL 12-26 1920

20. UNDERTAKER A. W. Conover

ADDRESS Mtn Home Ida

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2020
File No. 32581
Registered No.

1. PLACE OF DEATH
County of Elmore
City of Mtn Home
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William S White

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Married

6. DATE OF BIRTH: Aug. (Month) 9 (Day) 1847 (Year)

7. AGE: 73 Yrs. 3 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: R.R. Man
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): St Albans Vt.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Albert W. White
(Address) Mountain Home Ida

15. Filed 12-10-1920 J. E. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 3 1920 to Nov. 4 1920 that I last saw h.... alive on Nov. 4 1920 and that death occurred on the date stated above, at 5.50 P.M.

The CAUSE OF DEATH* was as follows:
Myocarditis and Uremic Poisoning.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O P Hamilton M. D.
Nov. 30 1920 (Address) Mtn. Home Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mtn Home Cem. DATE OF BURIAL: Nov 11 1920

20. UNDERTAKER: A W Conover ADDRESS: Mtn Home Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32582
Registered No.

1. PLACE OF DEATH.
County of Elmore
City of Elmo's Ferry
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 35
Primary Registration District No. 2021
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Eugenia Shanbaum

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: May 15 (Month) (Day) 1896 (Year)

7. AGE: 24 yrs. 7 mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Bloomfield Nebraska

10. NAME OF FATHER: Charles Hurtert

11. BIRTHPLACE OF FATHER (State or Country): Europe

12. MAIDEN NAME OF MOTHER: Mary Kuyer

13. BIRTHPLACE OF MOTHER (State or Country): Europe

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Matilda Friedel
(Address): Elmo's Ferry Idaho

15.
Filed Dec. 26 1920 J. W. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 24, 1920, to Dec. 24, 1920 that I last saw her alive on Dec. 24, 1920, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
Concussion of brain
5 hours (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Automobile accident
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. W. Davis M. D.
Dec. 25 1920 (Address) Elmo's Ferry Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted.
If not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Blackfoot Idaho
DATE OF BURIAL: Dec. 27, 1920

20. UNDERTAKER: Joe Rubaum
ADDRESS: Elmo's Ferry Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32583
Registered No.

1. PLACE OF DEATH.
County of Elmore
City of King Hill
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36
Primary Registration District No. 2021
(No. ....., ... St.)

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Harold Buchanan Paul

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec. (Month) 9 (Day) 1918 (Year)

7. AGE: 2 yrs. mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): America

10. NAME OF FATHER: Max Paul

11. BIRTHPLACE OF FATHER (State or Country): America

12. MAIDEN NAME OF MOTHER: Madge Catharine Mink

13. BIRTHPLACE OF MOTHER (State or Country): America

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Paul
(Address): King Hill Idaho

15.
Filed Dec 31 1920
J. W. Davis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29. 1920, to Dec. 29. 1920 that I last saw him alive on Dec. 29. 1920, and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Extensive burns of body and head

(Duration) ..... yrs. ..... mos. 8 hrs ds.

Contributory (Secondary): Explosion of Coal oil or gasoline
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Davis M. D.
Dec. 31 1920 (Address) Elmore Army Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elmore Army Idaho
DATE OF BURIAL: Dec. 31 1920

20. UNDERTAKER: Joe Rueben
ADDRESS: Elmore Army Idaho

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be state EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 32586
Registered No. 80.

1. PLACE OF DEATH
County of Franklin
City of Preston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME alfred E. Willmore
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: June (Month) 27 (Day) 1874 (Year)

7. AGE: 46 Yrs. 5 Mos. 18 Ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: assistant miller
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Birmingham Eng.

10. NAME OF FATHER: Thomas Willmore

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Louisa Baldwin

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Willmore
(Address) Preston Idaho.

15. Filed Dec. 28 1920. D. A. Cudia Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1920, to Dec 14 1920
that I last saw h[illegible] alive on Dec 14 1920
and that death occurred on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows: Pulmonary Emphysema

(Duration) Yrs. [illegible] mos. 1 ds.
Contributory (Secondary) Fatal-Scatica neuro
(Duration) yrs. 6 mos. ds.
(Signed) Dr. D. A. Cardiss M. D.
Dec 16 1920 (Address) Preston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston Ida — DATE OF BURIAL: Dec 17 1920

20. UNDERTAKER: W. C. Steadmore — ADDRESS: Preston Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 32587
Registered No. 48

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Albiston

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: Jan (Month) 24 (Day) 1836 (Year)

7. AGE: 74 Yrs. 10 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: George Lee

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Sarah Peaker

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. W. Albiston
(Address) Franklin Idaho

15. Filed Dec 16 1920 D. A. R. Curtis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Dec 15 1920 that I last saw h.er alive on Dec 14 1920, and that death occurred on the date stated above, at 15 A. M.

The CAUSE OF DEATH* was as follows:
Broncho pneumonia

(Duration) ..... Yrs. ..... mos. 15 ds.
Contributory (Secondary) Chronic Bright's disease
(Duration) 5 yrs. - mos. 2 ds.

(Signed) G W Stites M. D.
Dec 16 1920 (Address) Preston, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Franklin
DATE OF BURIAL: Dec 17 1920

20. UNDERTAKER: W. A. Gledmore
ADDRESS: Preston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 27
Primary Registration District No. 2119
File No. 32588
Registered No. 99

1. PLACE OF DEATH
County of Franklin
City of Preston (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wendal Fellows
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Dec. 12 (Month) (Day) 1920 (Year)

7. AGE: X Yrs. X Mos. 3 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: William E. Fellows

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Maggie E. Roper.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm E Fellows
(Address) Preston

15. Filed 12 Dec. 1920. D. A. Rendes Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1920, to Dec. 15 1920 that I last saw h.i.m. alive on Dec 14 1920, and that death occurred on the date stated above, at 10.30 P M.

The CAUSE OF DEATH* was as follows:

Convulsions — cause unknown

(Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Curtis Blanch M. D.

12/16/1920 (Address) Preston, Idah.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: Dec 16 1920

20. UNDERTAKER: W. A. Steadmore
ADDRESS: Preston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32589
Registered No. 821

1. PLACE OF DEATH
County of Franklin
City of Preston
(No. ....., ... St.)
Registration District No. 27
Primary Registration District No. 2119
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Roper Buckley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.):

6. DATE OF BIRTH: Sept. 14 (Month) (Day) 1919 (Year)

7. AGE: 1 Yrs. 1 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: George B. Buckley

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Luvain Roper.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs E. Trellow
(Address) Preston

15. Filed Jan 7 1921 D. A. Cutler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 26 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920 to Oct 26 1920
that I last saw him alive on Oct 15 1920
and that death occurred on the date stated above, at 1:30 P. M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. 2 ds.
Contributory (Secondary) Malnutrition
(Duration) ..... yrs. 6 mos. ..... ds.
(Signed) A. R. Cutler M. D.
Oct 1920 (Address) Preston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Preston
DATE OF BURIAL: Oct 28 1920

20. UNDERTAKER: Ben Undertaker
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 32590
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John L. Armstrong
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH
..... 1.....
(Month) (Day) (Year)

7. AGE: about 25 yrs
Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farm Keeper
(b) General nature of industry, business or establishment in which employed (or employer): R. R. Construction

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Armstrong

11. BIRTHPLACE OF FATHER (State or Country): ——

12. MAIDEN NAME OF MOTHER: ——

13. BIRTHPLACE OF MOTHER (State or Country): ——

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Norman Arnold
(Address) St Anthony

15. Filed Dec 10 1920 W. D. Ward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 16 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 11:30 M.
The CAUSE OF DEATH* was as follows:
Gun shot Wound on head accidental
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Norman Arnold M. D.
..... 19..... (Address) Town

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State Killed while residing on train yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salt Lake City Utah — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Taylor-Edwards Mort. — ADDRESS St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 32591
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Hileman
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: May (Month) 17 (Day) 1837 (Year)

7. AGE: 83 Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pennsylvania

10. NAME OF FATHER: Not known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: Mary Ann Young

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) Penny Street St Anthony

15. Filed Dec 10 1920 W. D. Ward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 23" 1920, to Nov 26" 1920
that I last saw her alive on Nov 23" 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Heart failure

(Duration) ..... Yrs. 2 mos. ..... ds.
Contributory (Secondary) Arterio-sclerosis and Senile Marasmus
(Duration) several yrs. mos. ds.
(Signed) W. H. Rauchbauer M. D.
19..... (Address) Dr. Rauchbauer

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sowa Cemetery — DATE OF BURIAL: Dec 2 1920

20. UNDERTAKER: Taylor-Ellerson Co. — ADDRESS: St Anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 32592
Registered No. .....

1. PLACE OF DEATH.
County of Bingham
City of St Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Andrew McMinn

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH. July (Month) 6 (Day) 1857 (Year)

7. AGE 68 Yrs. 9 Mos. 20 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... farmer retired
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Canada

10. NAME OF FATHER Augusta McMinn

11. BIRTHPLACE OF FATHER Scotland (State or Country)

12. MAIDEN NAME OF MOTHER Don't Know

13. BIRTHPLACE OF MOTHER " " (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J McMinn
(Address) Parker Idaho

15. Filed Dec 10 1920 W Burt Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov 2[illegible] (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~191~~ ..... to ..... 191.....
that I last saw h..... alive on ..... 191.....
and that death occured on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows: I was found dead Probably
Sunk from Cardiac disease
.....(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W B Ward M. D.
.....19..... (Address) St Anthony Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Parker Ida	11 22 1920

20. UNDERTAKER	ADDRESS
Taylor Nelson	St Anthony Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOOKS. 24658

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 32593
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St. Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Abigail Smith Huff
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Oct (Month) 13 (Day) 879 (Year)

7. AGE: 40 Yrs. 11 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Andrew J. Bigler

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Anna Paul

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Charles Loy Huff
(Address) St. Anthony

15. Filed Nov 10 1920 W. S. Wurl, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 11" 1920, to Sept 24" 1920
that I last saw her alive on Sept 24" 1920
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Surgical shock from operation
for hysterectomy
(Duration) ..... yrs. ..... mos. 1 ds.
Contributory (Secondary) Uterine fibroids + anaemia
(Duration) 11 yrs. ..... mos. ..... ds.
(Signed) M. M. Harshbarger M. D.
19..... (Address) St. Anthony, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. 1 days. In the State ..... yrs. ..... mos. 1 days
Where was disease contracted if not at place of death?
Former or usual residence St. Anthony Idaho

19. PLACE OF BURIAL OR REMOVAL: Pioneer Cemetery — DATE OF BURIAL: Sept. 27 1920

20. UNDERTAKER: Taylor-Emerson Und. Co — ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32594
Registered No.

Registration District No. 99
Primary Registration District No. 2177

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Char Caleb Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Feby (Month) 17 (Day) 1866 (Year)

7. AGE: 54 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Butcher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New Jersey

10. NAME OF FATHER: C. P. Wright

11. BIRTHPLACE OF FATHER (State or Country): New Jersey

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. H. Wright
(Address)

15. Filed Nov 10 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920, to Oct. 16 1920
that I last saw him alive on Sept 16 1920
and that death occurred on the date stated above, at 5 P M.
The CAUSE OF DEATH* was as follows:

Cerebral Tumor

(Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary): General debility
(Duration) ..... yrs. 6 mos. ..... ds.

(Signed) J E Methon M. D.
Oct 16 1920 (Address) St Anthony Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mt Home — DATE OF BURIAL: Oct 17 1920

20. UNDERTAKER — ADDRESS —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 32595
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St. Anthony
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Paxton Lee Logan Roseborough
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: May (Month) 16 (Day) 1848 (Year)

7. AGE: 72 Yrs. 5 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: William Roseborough

11. BIRTHPLACE OF FATHER (State or Country): Pennsyloania

12. MAIDEN NAME OF MOTHER: Margaret Sarver

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Earl Roseborough
(Address) St. Anthony

15. Filed NOV 10 1920
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: October (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 9th 1920 to Oct 11- 1920, that I last saw h..... alive on ..... 19..., and that death occurred on the date stated above, at 5:10 P M.
The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis
Unknown
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Uremia
Unknown about one week
(Duration) ..... mos. ..... ds.
(Signed) J. Frank Watkins M. D.
19..... (Address) J. E. Melton M.D. St. Anthony

*State the Disease Causing Death; or in deaths from Violence, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 20 yrs. ..... mos. ..... days. In the State 20 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence St. Anthony Idaho

19. PLACE OF BURIAL OR REMOVAL: St. Anthony
DATE OF BURIAL: Oct 19 1920

20. UNDERTAKER: Payton-Elerson Studio
ADDRESS: St. Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

102

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont

City of Ashton

Registration District No. 102

Primary Registration District No. 2

(No. ..... St.)

File No. 32596

Registered No. 9

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward Lyman Humphrey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: S (Write the word.)

6. DATE OF BIRTH: Nov - 27 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ashton Idaho.

10. NAME OF FATHER: Edward Farley Humphrey

11. BIRTHPLACE OF FATHER (State or Country): Utah.

12. MAIDEN NAME OF MOTHER: Maria Clara Lyman Humphrey

13. BIRTHPLACE OF MOTHER (State or Country): Utah.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) Ashton, Ida.

15. Filed 12-18- 1920 C. McLean, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 14 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-9- 1920 to 12-14- 1920 that I last saw h[illegible] alive on 12-13 1920 and that death occurred on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Septicaemia

..... (Duration) ..... Yrs. ..... mos. 5 ds.

Contributory (Secondary) U.K.

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Kingsbury M. D.

12/15 1920 (Address) Ashton, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ashton, Ida. DATE OF BURIAL: 12/15 1920

20. UNDERTAKER [illegible] ADDRESS Ashton, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont

City of St Anthony (No. ..... St.)

Registration District No. 107

Primary Registration District No. 6

File No. 32598

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Albert Simons

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 16 (Day) 1871 (Year)

7. AGE: 49 Yrs. 7 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Payson Utah

10. NAME OF FATHER: Adelbert Simons

11. BIRTHPLACE OF FATHER (State or Country): Dont Know

12. MAIDEN NAME OF MOTHER: Martha Whitehead

13. BIRTHPLACE OF MOTHER (State or Country): Dont Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs James Simons
(Address) Marysville Ida

15. Filed 12 29 1920 [signature] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1920, to Dec 28 1920, that I last saw h[illegible] alive on Dec 28 1920, and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Gall stones

..... (Duration) 8 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [signature] M. D.

Dec 29 1920 (Address) [illegible]

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 19.....
20. UNDERTAKER	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32599
Registered No.

1. PLACE OF DEATH

County of Fremont

~~City of~~ Squirrel Idaho

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

2. FULL NAME Thelma Barbara Brown

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Sept. (Month) 16 (Day) 1919 (Year)

7. AGE: 1 Yrs. 3 Mos. 16 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Squirrel Idaho

10. NAME OF FATHER F. C Brown

11. BIRTHPLACE OF FATHER (State or Country) Kansas

12. MAIDEN NAME OF MOTHER Gladys Poertner

13. BIRTHPLACE OF MOTHER (State or Country) St Louis Mo

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) F. C. Brown

(Address) Squirrel Idaho

15. Filed Jan 1-0 1920 A. M. Woodhouse Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to Dec 29 1920 that I last saw h[illegible] alive on Dec 29 1920 and that death occurred on the date stated above, at 9 a M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 10 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F. C. Brown M. D.

Dec 29 1920 (Address) Ashton Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Squirrel Idaho — DATE OF BURIAL: 12-31 1920

20. UNDERTAKER: Lewis Kiser — ADDRESS: Ashton Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32600
Registered No.

1. PLACE OF DEATH
County of Dear Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No. 6
(No. , St.)

2. FULL NAME William F. Fuller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): widower

6. DATE OF BIRTH: Apr (Month) 19 (Day) 1845 (Year)

7. AGE: 75 Yrs. 8 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: Not Known

11. BIRTHPLACE OF FATHER (State or Country): " "

12. MAIDEN NAME OF MOTHER: " "

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. F. Fuller
(Address) Emmett Ida

15. Filed 1/5 1921 J. K. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10 1921, to Dec 23 1920 that I last saw h[illegible] alive on Dec 22 1920 and that death occurred on the date stated above, at 10 P M.
The CAUSE OF DEATH* was as follows:

Bronco Pneumonia

(Duration) Yrs. mos. 14 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) Burton O Clark M. D.
19 (Address) Emmett Ida

*State the *Disease Causing Death*; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Emmett Idaho
DATE OF BURIAL 19

20. UNDERTAKER: C. L. Tucknum
ADDRESS Emmett Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. .....

PLACE OF DEATH
County of Gem Registration District No. 6
City of Emmett Primary Registration District No. ..... Local Registrar's No. .....
(No.) Death occured at his sons home - George A. Fuller
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** William Fuller

(a) Residence. No. ..... St. .....
(Usual place of abode.) (If nonresident give city or town and State.)
Length of residence in city or town where death occured. ..... yrs. ..... mos. ..... ds. How long in U. S. if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
Male	white	widower

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year)

7. AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
About 76			

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work: Retired brewer
(b) General nature of industry, business, or establishment in which employed (or employer): and Maltster
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country): London England

PARENTS
10. NAME OF FATHER: Henry Fuller
11. BIRTHPLACE OF FATHER (city or town) (State or Country): England
12. MAIDEN NAME OF MOTHER: Mary Ann Thomas
13. BIRTHPLACE OF MOTHER (city or town) (State or County): England

14. Informant (Address): Fred J. Fuller Emmett Idaho

15. Filed Dec 26, 1920 J. L. Reynolds Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 10, 1920, to Dec. 23, 1920, 19.....
that I last saw him alive on Dec. 22, 1920, 19.....
and that death occurred, on the date stated above, at 10 P m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(Signed by Burton O. Clark)

(Copied from original)

.....(duration) .....yrs. .....mos. 14 ds.

CONTRIBUTORY (Secondary) .....

.....(duration) .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? no Date of .....
Was there an autopsy? no
What test confirmed diagnosis? none
(Signed) B. O. Clark M. D.
Dec 26, 1920 (Address) .....

19. Place of Burial, Cremation, or Removal	Date of Burial
Emmett Idaho	Dec 26 1920
20. Undertaker: O. Buckman	Address: Emmett Idaho

FORM V. S. No. 5-25 [illegible]

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32661

Registered No.

1. PLACE OF DEATH

County of Boise

City of Brownlee

Registration District No. 6

Primary Registration District No.

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Bemus

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Girl	White	Infant

6. DATE OF BIRTH: Sept (Month) 13 (Day) 1920 (Year)

7. AGE: ..... Yrs. 3 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer's Wife

(b) General nature of industry, business or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): Brownlee

10. NAME OF FATHER: W. E. Bemus

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jamima Seley

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Bemus

(Address) Gardena Ida

15. Filed Dec 28 1920 Jessie Eaton Local Registrar

J. R. Reynolds

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 23 1920 to Dec 24 1920 that I last saw h[illegible] alive on Dec 24 1920 and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Pertussis

(Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) Bronchial Pneumonia

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. J. Reynolds M. D.

1/2 1921 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sweet Ida	Dec 26 1920

20. UNDERTAKER	ADDRESS
Family	

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32602

Registered No.

Registration District No.

Primary Registration District No. 6

(No. , St.)

1. PLACE OF DEATH

County of Boise

City of Gardena

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Henry Hill

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 25 (Day) 1839 (Year)

7. AGE: 80 Yrs. 11 Mos. 5 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minnie Penn.

10. NAME OF FATHER: Andrew J Hill

11. BIRTHPLACE OF FATHER (State or Country): Alabama

12. MAIDEN NAME OF MOTHER: Eliza Tillden

13. BIRTHPLACE OF MOTHER (State or Country): Alabama

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Lawson Hill

(Address) Gardena Ida

15. Filed 12/13 1920

J. L. Reynolds
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....,

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Possibly Cerebral Hemorrhage
no Doctor in attendance

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. Reynolds M. D.

19..... (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bramlee Cemetery

DATE OF BURIAL: Dec 3 1920

20. UNDERTAKER: Gardena Ida

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32603

Registered No.

1. PLACE OF DEATH

County of Gem

City of Emmett

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Russell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	white	single

6. DATE OF BIRTH: Feb (Month) 26 (Day) 1886 (Year)

7. AGE: 34 Yrs. 9 Mos. 22 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Thomas Russell

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Elizabeth Jose

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Thos Russell
(Address): Emmett Idaho

15. Filed 12/21 19 20 — J. L. Reynolds, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 12 1920 to Dec 18 1920, that I last saw him alive on Dec 18 1920, and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

(Duration) 3 Yrs. mos. 3 ds.

Contributory (Secondary): Pyorrea

(Duration) Several yrs. mos. ds.

(Signed) J. L. Reynolds M. D.

12/20 1920 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Ida	12/21 1920

20. UNDERTAKER	ADDRESS
E. D. Bucknum	Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 6
(No. ....., ... St.)

File No. 32604
Registered No. .....

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Claude Harris Carpenter
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Male	White	Single (Write the word.)

6. DATE OF BIRTH: Apr (Month) 12 (Day) 1904 (Year)

7. AGE: 16 Yrs. 7 Mos. 8 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Boyd Carpenter

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Vernessa Harris

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. B. Carpenter
(Address) Emmett Idaho

15. Filed 12/13 1921 J. V. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 24 1920, to Nov 19 1920
that I last saw him alive on Nov 19 1920
and that death occurred on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:
Acute Nephritis
Chronic Myocarditis
..... (Duration) ..... Yrs. 1 mos. ..... ds.
Contributory (Secondary) Scarlet fever
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R R Cummings M. D.
11/22/1920 (Address) Emmett Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	11/21 1920
20. UNDERTAKER C. D. Bucknum	ADDRESS Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

6 R

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. ____
Primary Registration District No. 6
(No. ____, ____ St.)

File No. 32605
Registered No. ____

1. PLACE OF DEATH
County of Gem
City of Emmett
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary McAnulty

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	married

6. DATE OF BIRTH: May (Month) 1 (Day) 1859 (Year)

7. AGE: 61 Yrs. 6 Mos. 16 ds. IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Benjamin Thornburg

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Not Known

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Theo McAnulty
(Address) Emmett Idaho

15. Filed 12/13/1920 J. L. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ____ 19____, to ____ 19____ that I last saw h____ alive on ____ 19____, and that death occurred on the date stated above, at about 10 A.M.

The CAUSE OF DEATH* was as follows:
Probably a Cerebral Hemorrhage

(Duration) ____ Yrs. ____ mos. ____ ds.
Contributory (Secondary) Atrio-sclerosis
(Duration) Several yrs. ____ mos. ____ ds.

(Signed) R N Cummings M. D.
11/18 1920 (Address) Emmett

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Emmett Idaho	11/21/1920
20. UNDERTAKER	ADDRESS
C. A. Buckner	Emmett Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 32608
Registered No.

1. PLACE OF DEATH.
County of Gooding
City of Gooding
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Nathan Rose Woodworth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widower

6. DATE OF BIRTH. Sept (Month) 4 (Day) 1839 (Year)

7. AGE: 81 Yrs. 2 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Don't Know

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Don't Know

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs G Abernathy
(Address) Gooding Idaho

15. Filed Jan 10 1924
F J Cary MD
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28 1920, to Dec 3rd 1920, that I last saw him alive on Dec 2 1920, and that death occured on the date stated above, at 3.30 M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) F J Cary M. D.

12/6 1920 (Address) Gooding Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone, Ida — DATE OF BURIAL: 12-6 1920

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding, Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
(No. .... St.)

File No. 32609
Registered No.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Gooding
City of Gooding
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rilla Annie Pilgrim —

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White —
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married —

6. DATE OF BIRTH.
January (Month) 11 (Day) — 1866 (Year)

7. AGE
54 Yrs. 10 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Missouri —

10. NAME OF FATHER Daniel Fisher —

11. BIRTHPLACE OF FATHER
(State or Country) Virginia —

12. MAIDEN NAME OF MOTHER Miss Moore

13. BIRTHPLACE OF MOTHER
(State or Country) Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Orletia Thompson
(Address) Gooding, Idaho —

15.
Filed Dec 6 1920
F J Cary
Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 28 1920, to Dec 5th 1920, that I last saw her alive on Dec. 3rd 1920 and that death occured on the date stated above, at 1:50 A.M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver —
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration ..... yrs. ..... mos. ..... ds.
(Signed) F W Cary M. D.
12/6 1920 (Address) Gooding, Idaho —

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gooding Cemetery
DATE OF BURIAL: Dec 6 1920

20. UNDERTAKER: AE Thompson
ADDRESS: Gooding, Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No.
File No. 32610
Registered No.

1. PLACE OF DEATH
County of Gooding
City of Gooding
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Plimpton Byron Dickerson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH: July 16th 1866 (Month) (Day) (Year)

7. AGE: 64 Yrs. 5 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lowell Indiana

10. NAME OF FATHER: Dickerson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Dora Rucow

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Drewry Dickerson
(Address) Gooding Ida

15. Filed Dec 10 1920 F. J. Carey
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12th 1920, to Dec 8th 1920, that I last saw h~~im~~ alive on Dec 7th 1920, and that death occurred on the date stated above, at 3:20 A.M.

The CAUSE OF DEATH* was as follows:
Chronic gastric ulcer

(Duration) 20 Yrs. mos. ds.
Contributory (Secondary) Closure of pyloros
(Duration) yrs. 1 mos. 14 ds.

(Signed) J H Cromwell M. D.
12/8/1920 (Address) Gooding Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Gooding	Dec 10 1920
20. UNDERTAKER: A E Thompson	ADDRESS: Gooding Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32611

Registered No. 36

Registration District No. 103

Primary Registration District No. 1001

(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Grangeville

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louise Reinemer

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Oct 7 1914 (Month) (Day) (Year)

7. AGE ..... Yrs. 14 Mos. 14 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Forest Grove Oregon

10. NAME OF FATHER Ralph W. Reinemer

11. BIRTHPLACE OF FATHER Colorado (State or Country)

12. MAIDEN NAME OF MOTHER Hilda Jaeckel

13. BIRTHPLACE OF MOTHER St Louis Missouri (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) R W Reinemer

(Address) Grangeville Idaho

15. Filed Jan 1 1921 G S Stratton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 22 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1920, to Dec 22 1920, that I last saw her alive on Dec 22 1920, and that death occured on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

..... (Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stratton M. D.

12/22/1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Grove Ore — DATE OF BURIAL: 191

20. UNDERTAKER: E Hanenck — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 103

Primary Registration District No. 1001

File No. 32612

Registered No. 31

County of Idaho

City of Grangeville

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Carrol Graves

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 4 (Day) 1868 (Year)

7. AGE: 52 Yrs. ..... Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Albany Oregon

10. NAME OF FATHER: John Calvin Graves

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Frances Jane Mayes

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Leora P. Martin

(Address) 697 S. Liberty St. Salem Ore.

15.

Filed Jan 1 1921

G S Stockton
Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920, to Dec 7 1920, that I last saw h[illegible] alive on Dec 7 1920, and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

12/9 1920 (Address) Grangeville Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Prairie View Grangeville — DATE OF BURIAL: 12/10 1920

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
(No. ....., ... St.)

File No. 32614
Registered No. 98

1. PLACE OF DEATH.
County of Idaho
City of Clearwater
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Martha Ann Holland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov (Month) 7th (Day) 1917 (Year)

7. AGE: 27 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Invalid
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Arkansas

10. NAME OF FATHER: Wm G. Holland

11. BIRTHPLACE OF FATHER (State or Country): Tennessee

12. MAIDEN NAME OF MOTHER: Mary C Gunter

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm G Holland
(Address) Clearwater

15. Filed Nov 10 1920
J M Weber Clerk
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920, to Nov 4 1920, that I last saw h SY alive on Nov 4 1920, and that death occured on the date stated above, at 11 35a M.

The CAUSE OF DEATH* was as follows:
Uncontrollable vomiting
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) Bedfast mit chronic articular rheumatism
(Duration) 6 yrs. mos ds.
(Signed) H. W. Whitworth M. D.
Nov 5 1920 (Address) Elder Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Clearwater | DATE OF BURIAL: Nov 1920

20. UNDERTAKER: Feeney | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
(No. ..... St.)

File No. 32615
Registered No. 100

1. PLACE OF DEATH.
County of Idaho
City of Elk City
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Elizabeth Litchfield

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (write word.): Married

6. DATE OF BIRTH.
November (Month) 8 (Day) 1857 (Year)

7. AGE
63 Yrs. - 15 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): San Francisco Calif

10. NAME OF FATHER: James Smith.

11. BIRTHPLACE OF FATHER (State or Country): Stockport England

12. MAIDEN NAME OF MOTHER: Sarah E. Grant.

13. BIRTHPLACE OF MOTHER (State or Country): Stockport England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Charles Litchfield
(Address) Elk City Idaho

15.
Filed Nov 25 1920 J M Wetherburn
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 3rd 1920, to Nov 23rd 1920, that I last saw h Sr alive on Oct 3rd 1920, and that death occured on the date stated above, at 6a M.
The CAUSE OF DEATH* was as follows:
Cancer of ascending colon

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) W W Wentworth M. D.
Nov 23 1920 (Address) Stites Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Elk City Ida.
DATE OF BURIAL 191

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 106
Primary Registration District No. 2184
(No. ....., ... St.)

File No. 32616
Registered No. 99

1. PLACE OF DEATH.
County of Idaho
City of Nezperce
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clarence Harris Prescott

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 27 (Day) 1857 (Year)

7. AGE: 63 Yrs. 6 Mos. 14 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Harris

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P. G. Barley
(Address) Lewiston, Idaho

15. Filed Nov 14 1920

J. M. Underwood
Local Registrar

SYMS - YORK CO., PTRS. & BOOK. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
November (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
No medical attendance
Death probably due to exposure
and generally weakened condition
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Underwood M. D.
Nov 14 1920 (Address) Kooskia - Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kooskia Idaho
DATE OF BURIAL: Nov 17 1920

20. UNDERTAKER: Geo Tenney
ADDRESS: Kooskia - Idaho

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
Registration District No. 98
County of Jefferson
Primary Registration District No. 2176
File No. 32617
City of Rigby (No. ....., ... St.)
Registered No. 43
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marion Arthur Marchant

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH: Nov 22 1920
(Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: J W. Marchant

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Julia Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J W. Marchant
(Address) Rigby R.F.D. 2

15. Filed 12/10 1920 Ray Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec 9 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1920 to Dec 7 1920, that I last saw h.m alive on Dec 6 1920 and that death occurred on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(Duration) ..... yrs. ..... mos. 3 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O. F. Call M. D.
12/10 1920 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby
DATE OF BURIAL: Dec 11 1920

20. UNDERTAKER: .....
ADDRESS: .....

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 98

County of Jefferson Primary Registration District No. 2176

City of Lewisville (No. ....., ... St.)

File No. 32620

Registered No. 40

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
F	White	single

6. DATE OF BIRTH: Nov 13 1920 (Month) (Day) (Year)

7. AGE: Stillborn ..... yrs. ..... mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER J. T. Wilson

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Rowena Jardine

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. T. Wilson
(Address) Lewisville Ida

15. Filed 12/10 1920 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov 13 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191..., that I last saw h..... alive on ..... 191..., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Stillborn

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A. M. Palmer M. D.

12/10 1920 (Address) Rigby

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewisville | DATE OF BURIAL: Nov 14 1920

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 32622
Registered No.

1. PLACE OF DEATH
County of Jefferson
City of Rigby
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma J. Cummings
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Dec 16 (Month) (Day) 1889 (Year)

7. AGE: 30 Yrs. 11 Mos. 28 ds.
IF LESS than 1 day how many..... hrs. or.....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Colo.

10. NAME OF FATHER: Jabez Dirden

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Pickles

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo. Cummings.
(Address) Rigby, Ida.

15. Filed Dec 15 1920
Ray W Fisher
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 14 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 26 1920 to Dec 14 1920
that I last saw h.. alive on Dec 14 1920
and that death occurred on the date stated above, at 4.40 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia.

.....(Duration) .....Yrs. ..... mos. 18 ds.
Contributory (Secondary) Pleurisy with Effusion.
.....(Duration) ..... yrs. ..... mos. ..... ds.
Acute Articular Rheumatism

(Signed) Ray W Fisher M. D.
Dec 15 1920 (Address) Rigby, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Boulder, Colo. DATE OF BURIAL: Dec 17 1920

20. UNDERTAKER: J. R. Young. ADDRESS: Rigby, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 32625
Registered No. 30
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Donna Geraldine Chamberland

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Feb 24 1920 (Month) (Day) (Year)
7. AGE: ....yrs. 9 mos. 5 ds.
IF LESS than 1 day how many .....hrs. or .....mins.)
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....
9. BIRTHPLACE (State or Country): Idaho -
10. NAME OF FATHER: John J. Chamberland
11. BIRTHPLACE OF FATHER (State or Country): Mo.
12. MAIDEN NAME OF MOTHER: Vira Lewis
13. BIRTHPLACE OF MOTHER (State or Country): Washington
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Chamberland
(Address) Rigby, Idaho
15. Filed 12/10 1920 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 11 - 28 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 15 1920 to Nov 27 1920, that I last saw h[illegible] alive on Nov 27 1920 and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

.....(Duration) ....yrs. ....mos. ....ds.
Contributory (Secondary) Acute Gastritis
.....(Duration) ....yrs. ....mos. ....ds.
(Signed) O. B. Bellar M. D.
11/30 1920 (Address) Roberts, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Lewisville
DATE OF BURIAL: 11-30 1920
20. UNDERTAKER: W R S. Young
ADDRESS: Rigby

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ..... St.)

File No. 32626
Registered No. 32
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ray Neal Jack Ralph

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single

6. DATE OF BIRTH: May 26 1919
(Month) (Day) (Year)

7. AGE: 1 yrs. 4 mos. 8 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Wallace R. Ralph

11. BIRTHPLACE OF FATHER (State or Country): S. Dakota

12. MAIDEN NAME OF MOTHER: Louise Ritter

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. R. Ralph
(Address) Rigby Ida

15.
Filed 12/10 1920 Ray H. Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 3 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1 1920; to Oct 3 1920,
that I last saw him alive on Oct 3 1920
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows: Cholera Infantum

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Ray H. Fisher M. D.
Oct 5 1920 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby
DATE OF BURIAL: 10-6 1920

20. UNDERTAKER: W. S. Young
ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & SDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 32627
Registered No. 31

1. PLACE OF DEATH.
County of Jefferson
City of Rigby (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dean Lessey
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 20 (Day) 1906 (Year)

7. AGE: 13 yrs. 11 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Chester R. Lessey

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Annetta Udy

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chester R. Lessey
(Address) Rigby Ida

15. Filed 12/10 1920 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 25 1920 to Nov 20 1920, that I last saw h imalive on Nov 1 1920 and that death occurred on the date stated above, at 5 A M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) A. M. Palmer M. D.
Nov 22 1920 (Address) Rigby, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rigby
DATE OF BURIAL: 11-23 1920

20. UNDERTAKER: W. L. Young
ADDRESS: Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 98
County of Jefferson Primary Registration District No. 2176
City of Lewisville (No. ....., ... St.)
File No. 32628
Registered No. 33
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Dora Bartholomew
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): Single
6. DATE OF BIRTH: Oct 8 1920 (Month) (Day) (Year)
7. AGE: ..... yrs. ..... mos. 15 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho.
10. NAME OF FATHER: Clifford Bartholomew
11. BIRTHPLACE OF FATHER (State or Country): Iowa
12. MAIDEN NAME OF MOTHER: Maude Hallibaugh
13. BIRTHPLACE OF MOTHER (State or Country): Wyo.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Clifford Bartholomew
(Address) Lewisville
15.
Filed 12/10 1920 Ray H Fiske Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct (Month) 23 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920 to Oct 23 1920
that I last saw her alive on Oct 20 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Congenital Atalectasis
(Duration) ..... yrs. ..... mos. 15 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) H A Anderson M. D.
Oct 24 1930 (Address) Rigby Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 10/26 1920
20. UNDERTAKER: W.L. Young — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Lorenzo (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176

File No. 32629
Registered No. 34
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Cecelia Thayne

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Oct 25 1920 (Month) (Day) (Year)

7. AGE: ..... yrs. ..... mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho -

10. NAME OF FATHER: Albert Thayne

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Jennie May Ellis

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Albert Thayne
(Address): Lorenzo Ida

15. Filed 12/10 1920 Ray Finley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 29 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 25 1920, to Oct 29 1920, that I last saw her alive on Oct 29 1920, and that death occurred on the date stated above, at 11 P M.

The CAUSE OF DEATH* was as follows:
Jaundice Neonatorum

..... (Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary): Toxemia
..... (Duration) ..... yrs. ..... mos. 4 ds.

(Signed) O. F. Coil M. D.
Oct 30 1920 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Annis
DATE OF BURIAL: 10-31 1920

20. UNDERTAKER: W. L. Young
ADDRESS: Rigby

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Rigby (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176

File No. 32630
Registered No. 33
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Frank Hardesty

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (*Write* the word.): married
6. DATE OF BIRTH: June 26 1860 (Month) (Day) (Year)
7. AGE: 60 yrs. 2 mos. 4 ds.
IF LESS than 1 day how many ..... *hrs. or* ..... *mins.?*
8. OCCUPATION
(a) Trade, profession or particular kind of work: Druggist
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Iowa
10. NAME OF FATHER: Don't know
11. BIRTHPLACE OF FATHER (State or Country): Virginia
12. MAIDEN NAME OF MOTHER: Don't know
13. BIRTHPLACE OF MOTHER (State or Country): Ohio -
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Frank Hardesty
(Address) Rigby, Ida
15.
Filed 12-10 1920 Ray H. Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 1 1920 (Month) (Day) (Year)
17. I HEREBY CERTIFY, That I attended deceased from Aug 2 1920; to Sept 1 1920; that I last saw h.m alive on Aug 31 1920, and that death occurred on the date stated above, at 9 A.M.
The CAUSE OF DEATH* was as follows:
Asthma
Myocarditis
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) 3 yrs. ..... mos. ..... ds.
(Signed) O. F. Call M. D.
Sept 2 1920 (Address) Rigby

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ida Falls
DATE OF BURIAL: Sept 3 1920
20. UNDERTAKER: Taylor-Ellerson Co
ADDRESS, Rigby

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

Amended Nov. 1, 1951

United States
Department of Commerce
Bureau of the Census

Certificate Of Death

STATE OF IDAHO

State File No. 32631
Local Reg. No. 36
Reg. Dist. No. 98

Informant, Funeral Director, Registrar and Medical Attendant, EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215). Address correspondence to State Bureau of Vital Statistics, Boise, Idaho.

1. **PLACE OF DEATH:**
   (a) County Jefferson
   (b) City or town Rigby
   (c) Street Address or R. F. D. No.
   (d) Death Occured Inside? Outside? city or town
   (e) Died in a Home Hospital Institution Other place
   (f) Name Hosp. or Inst. Stayed days
   (g) Lived in this county years months days

   Note. For a person residing in THIS county LESS than 1 year, give FORMER residence under item 2.

2. **Usual Residence of Deceased:** (Always fill in these)
   (a) State (b) County
   (c) City or town
   (d) Street Address or R.F.D. No.
   (e) Deceased lived Inside? Outside? city or town
   (f) Citizen of what country?
   (g) How long had deceased lived in Idaho? years
   (h) Former residence (city, state)

3. (a) **FULL NAME** John Kirn

3. (b) If veteran, name war
3. (c) Social Security No.
4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Date of Birth (Month, Day, Year) Don!t Know

8. AGE	Years	Months	Days	If less than 1 day
	62			hrs min.

9. Exact Occupation Farmer — Did this work for yrs.
10. Industry or Business — Date last worked
11. Birthplace (City or town) (State or foreign country)

Father
12. Name
13. Birthplace (City or town) (State or foreign country)

Mother
14. Maiden name
15. Birthplace (City or town) (State or foreign country)

16. Informant's **OWN** Signature Bash L. Bennett
    and Address Rigby
17. (a) (Burial, cremation, or removal) (b) Date thereof Oct. 20, 1920 (Month) (Day) (Year)
    (c) Place: Idaho Falls
18. Funeral Director's **OWN** Signature Taylor Elieson
    and Address Rigby
19. (a) 12-10, 1920 (Date received and filed) (b) Ray H. Fisher (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

20. **DATE OF DEATH** (Month, Day, Year) Oct. 18 19 20
    at o'clock M.
21. **I HEREBY CERTIFY,** That I attended deceased from Oct. 8 19 20, to Oct. 18 19 20
    I last saw him alive on Oct. 18 19 20; death is said to have occurred on the date and hour stated above.

Immediate Cause of Death:	Duration
Paralytic Ileus	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Where was disease contracted?	PHYISCIAN Underline the cause to which death should be charged statistically.
Name of operation Date	
Major finding	
Finding of autopsy	

22. If death was due to **EXTERNAL CAUSES,** also fill in the following: Accident? Suicide? Homicide?
    Occurred 19 City, county, state where violence occurred
    Place of Violence: Home Farm Industry
    Public Place While at work?
    Means of injury
23. Attendant's **OWN** Signature A. M. Palmer M.D. (M. D. or other)
    and Address Rigby, Idaho Date Oct. 19 19 20
    (For additional space, use reverse side)

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH—BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of IDAHO
County of JEFFERSON } ss.

Certificate No. 32631
Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for John Kearns (Name on Original Certificate) who died (Was Born or Died) on Oct. 18, 1920 (Date of Event)
in Rigby, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Homestead Patent (Bible Record, Insurance Policy, Etc.) prepared on March 1 - 1920 (Give Date), are:

Viewed by Div. of Vital Statistics

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
2. Full Name	John Kearns	John Kirn

Subscribed and sworn to before me this 26 day of October, 1954

Marion H Harrop
Notary Public, residing at Rigby Idaho
My commission expires June 7 1958
(Seal)

Signed W J Kremer
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Rigby, Idaho. Rt. #2
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of IDAHO
County of JEFFERSON } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 26th day of October, 1954

Ernest Ray
Notary Public, residing at Rigby, Idaho
My commission expires My Commission expires 8/7/57
(Seal)

Signed Nels Johnson
(Signature of Any Credible Person)

Rigby, Idaho. Rt. #2
(Street Address, City, State)

DPH 52.155

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 32631
Registered No. 36

1. PLACE OF DEATH.
County of Jefferson
City of Rigby (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Kearns

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Don't Know (Month) (Day) (Year)

7. AGE: 62 yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Don't Know

10. NAME OF FATHER: ,,

11. BIRTHPLACE OF FATHER (State or Country): ,,

12. MAIDEN NAME OF MOTHER: ,,

13. BIRTHPLACE OF MOTHER (State or Country): ,,

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Bash L. Bennett
(Address) Rigby

15. Filed 12/10 1920 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct 18 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 8 1920, to Oct 18 1920, that I last saw h[illegible] alive on Oct 18 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Paralytic Ileus

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) A M Palmer M. D.
Oct 19 1920 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Ida Falls
DATE OF BURIAL: Oct 20 1920

20. UNDERTAKER: Taylor Ellerson Co
ADDRESS: Rigby

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Menan (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176

File No. 32638
Registered No. 32638
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Alonzo Youngstrom

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	Single

6. DATE OF BIRTH
Dec 18 1920
(Month) (Day) (Year)

7. AGE
.....yrs. .....mos. .....ds.
IF LESS than 1 day how many .....hrs. or .....mins.

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Enoch Youngstrom

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Jane Johnston

13. BIRTHPLACE OF MOTHER (State or Country) Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Enoch Youngstrom
(Address) Menan, Ida

15.
Filed Dec 18 1920 Ray H Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec 18 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1920, to Dec 18 1920, that I last saw him alive on Dec 18 1920 and that death occurred on the date stated above, at 7-35 P. M.

The CAUSE OF DEATH* was as follows: Premature Birth

.....(Duration) .....yrs. .....mos. .....ds.

Contributory (Secondary) .....(Duration) .....yrs. .....mos. .....ds.

(Signed) Ray H Fisher M. D.
12/18 1920 (Address) Rigby Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Menan | DATE OF BURIAL: Dec 19 1920

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Jefferson
City of Hamer
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 98
Primary Registration District No. 2176
(No. ....., ... St.)

File No. 32633
Registered No. 37
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sarah C. Turman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: June 4 1854 (Month) (Day) (Year)

7. AGE: 66 yrs. 3 mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Thos E. Ricks

11. BIRTHPLACE OF FATHER (State or Country): Ky.

12. MAIDEN NAME OF MOTHER: Tabitha Hendricks

13. BIRTHPLACE OF MOTHER (State or Country): Ky.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James R. Turman
(Address) Hamer, Ida.

15. Filed 12/10 1920 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Sept 9 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 31 1920, to Sept 9 1920, that I last saw her alive on Aug 31 1920, and that death occurred on the date stated above, at 5P M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial nephritis - myocarditis - mitral regurgitation
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) unknown yrs. mos. ds.

(Signed) Harry L. Wilson M. D.
9/15 1920 (Address) Ida Falls

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ida Falls
DATE OF BURIAL: 9-11 1920

20. UNDERTAKER: C. E. Dunwoody
ADDRESS: Ida Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 79

Primary Registration District No. 1050

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32634

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene (No. 1308, Government-Wcy St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jens A. Westersund

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept. (Month) 9 (Day) 1871 (Year)

7. AGE: 48 Yrs. 9 Mos. 1 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Mill-Engineer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Norway

10. NAME OF FATHER: Anton Westersund

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs J. A. Westersund
(Address) .....

15. Filed June 17 1920 Gus Nelson Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 3 1920, to June 9 1920, that I last saw h in alive on June 8 1920, and that death occured on the date stated above, at 5:30 P.M.

The CAUSE OF DEATH* was as follows: Septic peritonitis following ruptured gangrenous appendix

6 (Duration) Yrs. mos. 6 ds.

Contributory (Secondary) .....

(Duration) yrs. mos. ds.

(Signed) J. P. N. Holden M. D.

6/12 1920 (Address) Coeur d'Alene Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 6-13 1920

20. UNDERTAKER: C. Casterday — ADDRESS: Athline

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene
Registration District No. 29
Primary Registration District No. 105
(No. 746 Government Way St.)
File No. 32635
Registered No. ,

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Marcil Gordon

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Sept- (Month) 8 (Day) 1865 (Year)

7. AGE: 54 Yrs. 9 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ore.

10. NAME OF FATHER: — Gordon

11. BIRTHPLACE OF FATHER (State or Country): — — — —

12. MAIDEN NAME OF MOTHER: — — —

13. BIRTHPLACE OF MOTHER (State or Country): — — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Eva Gordon
(Address)

15. Filed June 14 1920 Gus Nelson Local Registrar

SYMS-YORK CO., PTRS. & BOBS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis
No Doctor attending
(was Christian Scientist?)
(Duration) Several Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Gus Nelson Local Registrar D.
June 13 1920 (Address) C D'Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lo Fo Bay, Idaho — DATE OF BURIAL: 6-15-1920

20. UNDERTAKER: C. Cassedy — ADDRESS: C D'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 1952
File No. 32636
Registered No.

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 523 Coeur d'Alene St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Doris Freeland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: March (Month) 21 (Day) 1875 (Year)

7. AGE: 45 Yrs. 4 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ills.

10. NAME OF FATHER: Thomas Box

11. BIRTHPLACE OF FATHER (State or Country): Ireland.

12. MAIDEN NAME OF MOTHER: ——Burrington

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Truman George Freeland
(Address) Coeur d' Alene

15. Filed July 24 1920 Geo Nelson Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 20 1920, to July 22 1920, that I last saw her alive on July 21 1920, and that death occurred on the date stated above, at 6 A.M.

The CAUSE OF DEATH* was as follows:
Gastric Carcinoma

(Duration) ..... Yrs. 6 mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
7/22 1920 (Address) Coeur d' Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. 1 mos. 7 days. In the State 13 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? Coeur d' Alene
Former or usual residence Coeur d' Alene

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetary
DATE OF BURIAL: 1-26 1920

20. UNDERTAKER: C. Cassedy
ADDRESS: Coeur d' Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 29
Primary Registration District No. 1050
File No. 32637
Registered No.

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gust Erickson
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Jan (Month) 29 (Day) 1886 (Year)

7. AGE: 34 Yrs. 5 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Time Keeper
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Minn.

10. NAME OF FATHER: Eric Ericksen

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Mary Johnson

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) O Hall
(Address) 448 Post St Spokane

15. Filed July 20 1920 Grace Nelson Local Registrar

STAR-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 18 1920, to ..... 19....., that I last saw h..... alive on July 18 1920, and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:
Car Explosion accident
Crushed to death
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Freeman M. D.
7/20 1920 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Dallas. Ore.
DATE OF BURIAL: 7-22 1920

20. UNDERTAKER: C. Cassedy
ADDRESS: Coeur d'Alene

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32638

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Kootenai

City of Coeur d'Alene (No. 112 Cooler St.)

Registration District No 29

Primary Registration District No 1030

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John P. Farrell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Oct. (Month) 25 (Day) 1870 (Year)

7. AGE: 49 Yrs. 7 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Lumber grader

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Jos. Farrell

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: — Meeley

13. BIRTHPLACE OF MOTHER (State or Country): — —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Anita Bradbury

(Address) .....

15. Filed June 15 1920 Gus Nelson Local Registrar

SYMS-YORK CO., PTRS. & BDRS. 24858

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 12 1920, to June 14 1920, that I last saw h[illegible] alive on June 14 1920 and that death occured on the date stated above, at 5:30 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. 6 ds.

Contributory (Secondary) Tuberculosis & Organic Heart lesion

..... (Duration ..... yrs. — mos. 6 ds.

(Signed) W. K. Haeberle M. D.

6/14 1920 (Address) Coeur d Alene Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forest cemetery — DATE OF BURIAL: 6-16 1920

20. UNDERTAKER: C. Cassedy — ADDRESS: CdAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32639
Registered No. .....

1. PLACE OF DEATH.
County of Kootenai
City of Coeur d'Alene (No. 818, Foster St.)
Registration District No 24
Primary Registration District No 1050
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Emily Newhouse.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married
6. DATE OF BIRTH. June (Month) 11 (Day) 1848 (Year)
7. AGE: 72 Yrs. 1 Mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Ohio
10. NAME OF FATHER: Chas. Smith
11. BIRTHPLACE OF FATHER (State or Country):
12. MAIDEN NAME OF MOTHER: Elizabeth Anderson
13. BIRTHPLACE OF MOTHER (State or Country):
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wm Newhouse
(Address) 818 Foster, CDAlene
15. Filed July 13th 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 12 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from June 11 1920, to July 12 1920, that I last saw h er alive on July 12 1920, and that death occured on the date stated above, at 1030 A. M.
The CAUSE OF DEATH* was as follows:
Interstitial Nephritis
(Duration) 1 Yrs. 6 mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) J. O. Brown M. D.
July 13 20 (Address) Coeur d'Alene, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest- Coeur d'Alene — DATE OF BURIAL: 7-14 1920
20. UNDERTAKER: C. Carrecy — ADDRESS: CDAlene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYRD-RICHARDSON CO., PTG. & STNRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 24
Primary Registration District No. 1203
File No. 32640
(No. 6th St.)
Registered No. .....

1. PLACE OF DEATH.
County of Kootenay
City of Coeur d'Alene
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Gentry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Feb. (Month) 15 (Day) 1866 (Year)

7. AGE: 54 Yrs. 4 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Williamsport Pa.

10. NAME OF FATHER: Addam Mitchelltree

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) W. S. Gentry
(Address) Coeur d'Alene

15. Filed July 12th 1920 Gus Nelson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920, to July 10 1920, that I last saw h..... alive on July 10 1920, and that death occured on the date stated above, at 6 P.M.

The CAUSE OF DEATH*/ was, as follows:
Myocarditis
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Chronic Nephritis
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) S. D. Freeman M. D.
7/11 1920 (Address) Coeur d'Alene

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. C'Dalene — DATE OF BURIAL: 7-12 1920

20. UNDERTAKER: C. Cassedy — ADDRESS: C'Dalene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PTRS. & BOKS. 24858

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32641
Registered No.

1. PLACE OF DEATH.
County of Kootenai
City of Spirit Lake, Ida. (No. ....., ... St.)

Registration District No. 45
Primary Registration District No. 2122

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Clifton Anderson

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec (Month) 3 (Day) 1874 (Year)

7. AGE: 46 yrs. ..... mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: Brick layer
(b) General nature of industry business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: Cyrus Anderson

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Nannie Linxwiler

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Selma Anderson
(Address) Spirit Lake, Ida

15.
Filed 1/7 1920 Chas Kadrick Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 20 1920, to Dec 21 1920
that I last saw him alive on Dec 21 1920
and that death occurred on the date stated above, at 11:50 M.

The CAUSE OF DEATH* was as follows:
Double Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 20 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Carl E Prouty M. D.
1-8 1921 (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.L. Idaho.
DATE OF BURIAL: 1/2 1920

20. UNDERTAKER: O. W. Stone
ADDRESS: Rathdrum

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 10 11
(No. ..... St.)

File No. 32642
Registered No. 145

1. PLACE OF DEATH
County of Latah
City of Moscow
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clark Joseph Cameron
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 29 (Day) 1903 (Year)

7. AGE: 17 Yrs. 4 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Wm J. Cameron

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Louise Martin

13. BIRTHPLACE OF MOTHER (State or Country): Iowa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Wm J. Cameron
(Address): Moscow

15. Filed 12/28 1920 M. H. Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 13 1920, to Dec. 27 1920, that I last saw him alive on Dec. 27 1920, and that death occurred on the date stated above, at 9:30 P.M.
The CAUSE OF DEATH* was as follows:

Smallpox

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Gritman M. D.
12/28 1920 (Address)

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 12/29 1920

20. UNDERTAKER: Glen Bruce | ADDRESS: Moscow

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 61
Primary Registration District No. 1011
File No. 32643
Registered No. 143

1. PLACE OF DEATH
County of Latah
City of Moscow
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dupont Iddings.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: DES (Month) 16 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many 6 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho,

10. NAME OF FATHER E. J. Iddings

11. BIRTHPLACE OF FATHER (State or Country) Indiana

12. MAIDEN NAME OF MOTHER Maude Powell.

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) E. J. Iddings.
(Address) Moscow Ida

15. Filed 12/17 19.....
M. Hawthorne
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: DES (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 16 1920, to Dec. 16 1920, that I last saw h[illegible] alive on Dec. 16 1920, and that death occurred on the date stated above, at .....M.
The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

.....(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) Do not know
.....(Duration) .....yrs. .....mos. .....ds.

(Signed) .....M. D.
12/17 1920 (Address) Chas. L. Gritman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs. .....mos. .....days. In the State .....yrs. .....mos. .....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Moscow | DATE OF BURIAL: 12/17 1920

20. UNDERTAKER Glen Price | ADDRESS Moscow

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 61

Primary Registration District No. 1011

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32044

Registered No. 142

1. PLACE OF DEATH

County of Latah

City of Moscow

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward M. Carson.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Mch. (Month) 27 (Day) 1836 (Year)

7. AGE: 84 Yrs. ..... Mos. 8 ds. 11

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer): Proprietor

9. BIRTHPLACE (State or Country): Mich.

10. NAME OF FATHER: John Carson

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Not known

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) A. J. Greene

(Address) Spokane Wn.

15. Filed Dec 9th 1920 W. H. Carithers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 2 Dec. (Month) 8th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 22 1920, to Dec 17 1920

that I last saw him alive on Dec 17 1920

and that death occurred on the date stated above, at 8.45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis and Hutchinsons Bacterium infection

(Duration) 2 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Bacterial infection

Hemoturia

(Duration) ..... yrs. ..... mos. 14 ds.

(Signed) F. W. Leitch M. D.

12/9 1920 (Address) Moscow Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moscow — DATE OF BURIAL: 12/10 1920

20. UNDERTAKER: Glen Grigg — ADDRESS: Moscow

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Latah

City of Moscow

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 61

Primary Registration District No. 2141

File No. 32645

Registered No. 1447

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Melissa Beck.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Feb 27 1861
(Month) (Day) (Year)

7. AGE: 59 Yrs. 10 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: House wife

(b). General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: Stephen G. Barber

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Phoebe Carpenter

13. BIRTHPLACE OF MOTHER (State or Country): New York.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) P. G. Beck

(Address) Moscow

15. Filed 12/27 1920 W H Carothers Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 26 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 27 1920, to [redacted] 1920 that I last saw h.. alive on July 28 1920 and that death occurred on the date stated above, at 315 P.M.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

12/27 1920 (Address) Moscow, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Moscow	12/28 1920
20. UNDERTAKER	ADDRESS
Glen Price	Moscow

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 64
Primary Registration District No. 2144
File No. 32647
Registered No.

1. PLACE OF DEATH.
County of Latah
City of Moscow
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucian Berry Cattingham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Nov (Month) 2 (Day) 1863 (Year)
7. AGE: 57 yrs. 1 mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Traveling Salesman
(b) General nature of industry business, or dstablishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Indiana
10. NAME OF FATHER: — Cattingham
11. BIRTHPLACE OF FATHER (State or Country): —
12. MAIDEN NAME OF MOTHER: Elizabeth Ogenbaugh
13. BIRTHPLACE OF MOTHER (State or Country): Penna.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L. B. Cattingham
(Address) 2112 West Maxwell Spokane
15.
Filed Dec 9 1920 J. E. Pickard Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 9 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows!
Found Dead in Bed.
Probabal Heart Failure
No inquest held
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Glen Grill Coroner M. D.
12/9 1920 (Address) Moscow

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Spokane Wn. | DATE OF BURIAL: ..... 191...
20. UNDERTAKER: Glen Grill | ADDRESS: Moscow

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32651

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lemhi

City of Salmon, (No. ....., ... St.)

Registration District No. 41

Primary Registration District No. 2116

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Candace Smith

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: I

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. September 9 (Month) (Day) 1837 (Year)

7. AGE: 83 Yrs. 2 Mos. 27 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: George Martin

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Cynthia Welch

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Willis D. Hannan.

(Address) Salmon Idaho.

15.

Filed 12-10 1930 M. D. Greene Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 6" 1930 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 21 1930, to Dec. 6 1930, that I last saw her alive on Nov. 27" 1930, and that death occured on the date stated above, at 3.00 P.M.

The CAUSE OF DEATH* was as follows: Acute dilatation of heart.

..... (Duration) ..... Yrs. ..... mos. 1 ds.

Contributory (Secondary) Chronic Nephritis

..... (Duration) Several yrs. ..... mos. ..... ds.

12/7 1930 (Signed) C. B. Fulton M. D.

(Address) Salmon, Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 12-8" 1930

20. UNDERTAKER: Jno C. Dockler — ADDRESS: Salmon Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 4

Primary Registration District No. 2116

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32652
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Lemhi

City of Salmon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rose Standaker

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH. Feb. 22 1876
Dec. (Month) 14th (Day) 1920 (Year)

7. AGE 44 Yrs. 10 Mos. 15 ds.

IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Beaverville Ill

10. NAME OF FATHER Francis Besse

11. BIRTHPLACE OF FATHER (State or Country) Canada

12. MAIDEN NAME OF MOTHER Ozelda Morane

13. BIRTHPLACE OF MOTHER (State or Country) Montreal Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) George J. Standaker

(Address) Salmon Idaho

15. Filed 12/17 1920 M. D. Greene Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 14 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5 1920 to Dec 14th 1920
that I last saw her alive on Dec 14th 1920
and that death occurred on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

.....

.....

.....(Duration) 2 Yrs. ..... mos. 3 ds.

Contributory (Secondary) Chronic diabetes - for many years

.....(Duration) 20 Yrs. ..... mos. ..... ds.

(Signed) F S Wright M. D.

Dec 15 1920 (Address) Salmon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Boise Cemetery — **DATE OF BURIAL** 12-17th 1920

20. UNDERTAKER Am C Doebler — **ADDRESS** .....

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

Registration District No. 41

Primary Registration District No. 2116

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32653
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lemhi
City of Salmon
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizebeth Croford

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Single~~

6. DATE OF BIRTH. March 30th (Month) (Day) 1838 (Year)

7. AGE: 82 Yrs. 8 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER Thomas Wright

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Not known

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs C Bates
(Address) Salmon Ida

15.
Filed 1-10 1920 W. D. Greene
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH December 20th 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at 8-10 A.M.

The CAUSE OF DEATH* was as follows:
Valvular heart disease Due to old age
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) W. C. Doebler Coroner ~~M. D.~~
1-7-1921 (Address) Salmon, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Salmon Cemetery — DATE OF BURIAL: 12-22" 1920

20. UNDERTAKER: W. C. Doebler — ADDRESS: Salmon Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 47

Primary Registration District No.

(No. ..... , ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32654

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis

City of Peck, Star Route

If death occurs away from usual residence, give facts called for under special information. Idaho

2. FULL NAME Sarah Angeline Parsons

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec. (Month) 12, (Day) 920. (Year)

7. AGE ..... Yrs. ..... Mos. 1 1/2 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer): infant

9. BIRTHPLACE (State or Country) Peck, Ida. Star Route

10. NAME OF FATHER John Parsons

11. BIRTHPLACE OF FATHER (State or Country) Leland Idaho.

12. MAIDEN NAME OF MOTHER Minnie May Willoughby

13. BIRTHPLACE OF MOTHER (State or Country) Steele, Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Jno Parsons

(Address) Steele Idaho.

15. Filed 1—2 1921 Albert Huff Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 12 1920, to Dec. 14, 1920., that I last saw her alive on Dec. 12, 1920, and that death occured on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Congenital Heart Defect

(Duration) ..... Yrs. ..... mos. 1 1/2 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) P E Douglas M. D.

12. 16 (Address) Graigmont, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Steele Cemetery — DATE OF BURIAL: 12/15 1920.

20. UNDERTAKER: Jno. Parsons — ADDRESS: Steele, Idaho

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 49

Primary Registration District No. 2428

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32655

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lewis

City of Kamiah

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alpha Louisa Smith

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: fe

4. COLOR OR RACE: Wht

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH. Oct (Month) 7 (Day) 1839 (Year)

7. AGE: 81 Yrs. 2 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Indiana

10. NAME OF FATHER: James Green

11. BIRTHPLACE OF FATHER (State or Country): Ind

12. MAIDEN NAME OF MOTHER: Mary Gregory

13. BIRTHPLACE OF MOTHER (State or Country): Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J W Kinsight
(Address) Orangeville

15. Filed 12/13 1920 C J Johnson Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1920, to Dec 1920, that I last saw her alive on Dec 12 1920, and that death occured on the date stated above, at 5:40 P.M.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency

(Duration) ? Yrs. 5 mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) O H Bryson M. D.

12-13 1920 (Address) Kamiah Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Woodland Cem — DATE OF BURIAL: 12/14 1920

20. UNDERTAKER: C J Johnson — ADDRESS: Kamiah Ida

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

Registration District No. 16

Primary Registration District No. 7016

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32656

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Lemhi

City of Salmon

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Madeline Methebell Hunton.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 5 (Day) 1894 (Year)

7. AGE: 26 Yrs. 7 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Wife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Nebraska. Fremont.

10. NAME OF FATHER: Frank M. Stewart

11. BIRTHPLACE OF FATHER (State or Country): Penn.

12. MAIDEN NAME OF MOTHER: Ida Raidam

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) O. H. Dell

(Address) Salmon

15.

Filed Dec 6 1920

J. L. Tuttle
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1920, to Dec 5 1920, that I last saw h[er] alive on Dec 5 1920, and that death occured on the date stated above, at 4 A M.

The CAUSE OF DEATH* was as follows:

Puerperal Septicemia.

..... (Duration) ..... Yrs. ..... mos. 12 ds.

Contributory (Secondary) Obstruction of bowels & mucous

..... (Duration ..... yrs. ..... mos. 12 ds.

(Signed) O. H. Dell M. D.

12 1920 (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. 12 days. In the State 2 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? Redfield Ida

Former or usual residence Redfield Ida

19. PLACE OF BURIAL OR REMOVAL: Sequam Wash — DATE OF BURIAL: Dec 6 1920

20. UNDERTAKER: O. J. Swanson — ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
(No. .... St.)

File No. 32657
Registered No. 30

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin Kidwell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. Dec 21 1857
(Month) (Day) (Year)

7. AGE: 62 Yrs. 11 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Martin Berry Kidwell

11. BIRTHPLACE OF FATHER (State or Country): Kentucky

12. MAIDEN NAME OF MOTHER: unknown

13. BIRTHPLACE OF MOTHER (State or Country): Kentucky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. C. R. Tuttle
(Address) Tampa Idaho

15. Filed Dec 11 1920
J. L. Tuttle
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 11 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 3 1920, to Dec 11 1920, that I last saw him alive on Dec 11 1920, and that death occured on the date stated above, at 5-10 A.M.

The CAUSE OF DEATH* was as follows:
Cerebral Embolism
Pneumonia - confirmed by autopsy
(Duration) 1 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Alcoholism
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) G. O. Jones M. D.
19..... (Address) Shoshone, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone
DATE OF BURIAL: Dec 12 1920

20. UNDERTAKER: O. J. Brennan
ADDRESS: Shoshone

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 16
Primary Registration District No. 1016
(No. ....., ... St.)

File No. 32658
Registered No. 31

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Lincoln
City of Shoshone

2. FULL NAME August Schuppeniers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. April (Month) 18 (Day) 1876 (Year)

7. AGE: 44 Yrs. 9 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Railroading
(b) General nature of industry, business, or establishment in which employed (or employer): Track worker

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: August Schuppeniers

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Ina Wagner

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Lizzie Schuppeniers
(Address) Shoshone Idaho

15. Filed December 24 1920
Local Registrar

SYMS - YORK CO., PTRS. & BOOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 24 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/24 1920, to 12-24- 1920
that I last saw him alive on 12/24 1920,
and that death occured on the date stated above, at 8:20 A.M.
The CAUSE OF DEATH* was as follows:
Fracture of base of the brain and Concussion of brain
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary): none
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) C. F. Bauch M. D.
19..... (Address) Shoshone Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Shoshone Idaho
DATE OF BURIAL: 12-26 1920

20. UNDERTAKER: O. F. Brennan
ADDRESS: Shoshone

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM T. B. No. 6-15 M. 6-15-17.

1. PLACE OF DEATH
County of Madison
City of Rexburg
If death occurs away from usual residence, give facts called for under special information.

CERTIFICATE OF DEATH
Registration District No. 100
Primary Registration District No. .....
(No. ....., ... St.)

2. FULL NAME Hans Hansen

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32660
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widower

6. DATE OF BIRTH: April 24 1841 (Month) (Day) (Year)

7. AGE: 79 Yrs. 7 Mos. 28 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: Unknown

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Andrew Hansen
(Address) R.F.D.

15. Filed 12/29 1920 G. G. Espe Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 22 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21 at 1920 to Dec 22 1920
that I last saw h.M. alive on Dec 22 1920
and that death occurred on the date stated above, at 12:40 P. M.
The CAUSE OF DEATH* was as follows:
Senile debility
.....
.....
.....(Duration) ..... Yrs..... mos..... ds.
Contributory (Secondary) Acute indigestion
.....(Duration) ..... Yrs..... mos. 2 ds.
(Signed) Doris L. Rich M. D.
12/22 1920. (Address) Rexburg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Burton — DATE OF BURIAL: 12/26 1920

20. UNDERTAKER: Kenney — ADDRESS: Rexburg

N. B.—Every item of information should be carefully supplied. WRITE PLAINLY, WITH UNFADING INK—THE MARGIN RESERVED FOR should state CAUSE OF DEATH in plain terms, so that it may be understood. See instructions. of OCCUPATION is very important.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32661

Registered No. 74

1. PLACE OF DEATH

County of Minidoka

City of Rupert

(No. ..... St.)

Registration District No. 19

Primary Registration District No. 2013

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James H Hallister

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	White	married

6. DATE OF BIRTH: Sept (Month) 21 (Day) 1889 (Year)

7. AGE: 31 Yrs. 4 Mos. 5 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Ins Agent
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER A. J. Hallister

11. BIRTHPLACE OF FATHER (State or Country) Dont / Know

12. MAIDEN NAME OF MOTHER " "

13. BIRTHPLACE OF MOTHER (State or Country) " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Delilah M. Hallister
(Address) Rupert Idaho

15. Filed Dec 27 1920 E. W. Edmore Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1" 1920, to Dec. 26 1920, that I last saw ~~him~~ alive on Dec. 25 1920, and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as ~~follows:~~

Pulmonary Tuberculosis

(Duration) ..... Yrs. 18 mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) E. W. Edmore M. D.

12-27 1920 (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Chicago Ill — DATE OF BURIAL: Dec 1930

20. UNDERTAKER — ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

Please return immediately

CERTIFICATE OF DEATH

Ken

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32663

Registered No. 67

1. **PLACE OF DEATH**

County of Minidoka

City of Rupert

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 6

Primary Registration District No. 2015

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Dan Crain

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX** Male

4. **COLOR OR RACE** White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.)

6. **DATE OF BIRTH** Jan (Month) 14 (Day) 1857 (Year)

7. **AGE** 69 Yrs. 9 Mos. 17 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) New York

10. **NAME OF FATHER** Unknown

11. **BIRTHPLACE OF FATHER** (State or Country) " "

12. **MAIDEN NAME OF MOTHER** " "

13. **BIRTHPLACE OF MOTHER** (State or Country) " "

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) C. E. Williford

(Address) Rupert Idaho

15. Filed Dec. 2 1920

C. H. Elmore
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Oct (Month) 15 (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** ..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

no doctor called in last sickness

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. A Goodman M. D.

19..... (Address) Cowan Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL** Rupert Cemetery

DATE OF BURIAL Oct 18 1920

20. **UNDERTAKER** W. W. Goodman

ADDRESS Rupert

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 128
Primary Registration District No. Cuddesac
File No. 32664
Registered No.

1. PLACE OF DEATH
County of Nez Perce
City of Cuddesac Idaho (No. and Ward) (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joseph Henry Pottf

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 18 (Day) 1883 (Year)

7. AGE: 37 Yrs. 4 Mos. 12 ds.
IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pensylvania

10. NAME OF FATHER: William T. Pottf

11. BIRTHPLACE OF FATHER (State or Country): Pensylvania

12. MAIDEN NAME OF MOTHER: Mary E. Palmer

13. BIRTHPLACE OF MOTHER (State or Country): Pensylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary E. Dalquist
(Address) Cuddesac Idaho

15. Filed Nov. 1920 George Gaisford Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 1st (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 5th 1919, to Nov 1st 1920 that I last saw h[illegible] alive on Nov. 1st 1920 and that death occurred on the date stated above, at 9:15 A.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) Yrs. 22 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) George Gaisford M. D.
Nov 1920 (Address) Cuddesac Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: To Spokane Washington Cremation
DATE OF BURIAL: Nov 1920

20. UNDERTAKER: W. B. Williamson
ADDRESS: Lewiston Id.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No.
File No. 32665
Registered No.

1. PLACE OF DEATH.
County of Nez Perce
City of Lenore
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Valium Red Heart

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Indian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH.
(Month) (Day) 1 (Year)

7. AGE: 24 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: D Red Heart

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Anna

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) James Moore
(Address) Lenore

15.
Filed 12-22 1920
E E Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 191, to 191,
that I last saw h alive on 191,
and that death occured on the date stated above, at 4 P M.
The CAUSE OF DEATH* was as follows:
Gun Shot wound
Accidental
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration yrs. mos. ds.
(Signed) E Hemwell M. D.
19 (Address) Orofino

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Mar Lenore
DATE OF BURIAL: 12-22 1920

20. UNDERTAKER: M E Stoddard
ADDRESS: Clifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 32666
Registered No. 11

1. PLACE OF DEATH.
County of Nez Perce
City of Gifford
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William Henry Smathers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 17 (Day) 1839 (Year)

7. AGE: 81 Yrs. 1 Mos. 28 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Ind

10. NAME OF FATHER John K Smathers

11. BIRTHPLACE OF FATHER (State or Country) —

12. MAIDEN NAME OF MOTHER Nancy Belyeu

13. BIRTHPLACE OF MOTHER (State or Country) Ind

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Chas Smathers
(Address) Gifford Idaho

15. Filed Dec 16 1920 — E E Watts, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 15th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1920, to Dec 15 1920, that I last saw him alive on Dec 15 1920, and that death occured on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage
(Duration) — Yrs. — mos. 3 ds.
Contributory (Secondary)
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) E. E. Watts M. D.
19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Gifford Ida — DATE OF BURIAL: 12-19 1920

20. UNDERTAKER: W C Sudduth — ADDRESS: Gifford

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BOKS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 32667
Registered No. 12

1. PLACE OF DEATH
County of Nezperce
City of Melrose
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Benjamin Williams

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: May (Month) 30 (Day) 1855 (Year)

7. AGE: 65 Yrs. 6 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ontario

10. NAME OF FATHER: William Williams

11. BIRTHPLACE OF FATHER (State or Country): Canada

12. MAIDEN NAME OF MOTHER: Frances Cobblestick

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Abbie Williams
(Address) Melrose, Idaho

15. Filed Nov 6 1920
E E Watts
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November 5 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from November 3 1920, to November 5 1920, that I last saw him alive on November 4 1920, and that death occurred on the date stated above, at 6 A M.
The CAUSE OF DEATH* was as follows:

Endocarditis

(Duration) ? Yrs. ? mos. ? ds.
Contributory (Secondary) Rheumatic Fever
(Duration) 12 yrs. ..... mos. ..... ds.

(Signed) M. Alvad Gore M. D.
11/5 1920 (Address) Reubens, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Melrose Ida — DATE OF BURIAL: Nov 6 1920

20. UNDERTAKER: M E Stoddard — ADDRESS: Gifford

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 92
Primary Registration District No. 2170
File No. 32668
Registered No. 14

1. **PLACE OF DEATH**

County of Nez Perce
City of Lapwai
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Robert C. Collingwood

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Male

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Married

6. **DATE OF BIRTH**: May (Month) 1 (Day) 1845 (Year)

7. **AGE**: 75 Yrs. 7 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. **BIRTHPLACE** (State or Country): England

10. **NAME OF FATHER**: Thomas Collingwood

11. **BIRTHPLACE OF FATHER** (State or Country): England

12. **MAIDEN NAME OF MOTHER**: Sophia Sheild

13. **BIRTHPLACE OF MOTHER** (State or Country): England

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) .....
(Address) .....

15. Filed 12-19 1920 — E. E. Watts, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: Dec. (Month) 18 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Dec. 16 1920, to Dec. 18 1920, that I last saw him alive on Dec. 18 1920, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:

Obstruction of the bowels

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Stoneburner M. D.

19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Sunnyside — **DATE OF BURIAL**: Dec 20 1920

20. **UNDERTAKER** — **ADDRESS**

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 32669
Registered No. 3269

1. PLACE OF DEATH
County of Nezperce
City of Lewiston
(No. Whites Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Angus Ross Trimble

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 27 (Day) 1844 (Year)

7. AGE: 76 Yrs. 6 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Edward Trimble

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: Abbabilla Ross.

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alva E McClung
(Address)

15. Filed Dec 8 1921 Brown E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June Dec (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920 to Dec 9 1920
that I last saw h.was alive on Dec 9 1920
and that death occurred on the date stated above, at 5 30 P.M.

The CAUSE OF DEATH* was as follows:

Cortens Sclerosis
Acute Dilitation Heart (Immediate Cause)
(Duration) 3 Yrs. mos. ds.
Contributory (Secondary) Same
(Duration) yrs. mos. ds.

(Signed) E. L. White M. D.
Dec 10 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Lewiston Idaho — DATE OF BURIAL: 12/10 1920

20. UNDERTAKER — ADDRESS: Lewiston Ida

Rdt. Hayden.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 32670
Registered No. 3265

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Leggie Greene
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Jan. (Month) 9th (Day) 1845 (Year)

7. AGE: 75 Yrs. 11 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): Retired

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Levi Thomas

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Annie Block

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. White
(Address) Lewiston Ext. Idaho

15. Filed Jan 8 1921 Susan E Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 12 1920 to Dec. 13 1920 that I last saw h.r alive on Dec. 12 1920 and that death occurred on the date stated above, at 12:15 A.M.

The CAUSE OF DEATH* was as follows:

Paralysis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. M. Sly M. D.
12-13 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida
DATE OF BURIAL: 12/14 1920

20. UNDERTAKER .....
ADDRESS Ext. Lewiston Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 32671
Registered No. 566

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME J. O. Barnett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) ..... 1..... (Year)

7. AGE: 55 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) R. W. Hayden

(Address) Lewiston Ida.

15.

Filed Jan 8 1921

Susan E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw him alive on Dec. 15 1920,

and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Gunshot injury, suicide.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) L. J. Perkins M. D.

12/16/1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Lewiston Idaho

DATE OF BURIAL: 12/16/1920

20. UNDERTAKER

ADDRESS: Lewiston Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 32672
Registered No. 567

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Cornelius Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: July (Month) 23 (Day) 1845 (Year)

7. AGE: 75 Yrs. 4 Mos. 24 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wayne Co Michigan

10. NAME OF FATHER: Jacob Ellis

11. BIRTHPLACE OF FATHER (State or Country): Ontario

12. MAIDEN NAME OF MOTHER: Hana Tuttle

13. BIRTHPLACE OF MOTHER (State or Country): Canada

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Henry J. Thomas
(Address) Lewiston

15. Filed Jan 8 1921 Rom E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12 1 1915, to 12 17 1920
that I last saw h[illegible] alive on 12 16 1920.
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:

Cancer of Cerlon.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Reubens Idaho
DATE OF BURIAL: Statement 1/18 1920

20. UNDERTAKER: by Emo Brown
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 32673
Registered No. 5883

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston
(No. St. Joseph Hospital St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sister Mary Annunciata

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH ..... 1 .....
(Month) (Day) (Year)

7. AGE
87 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Nurse
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ireland

10. NAME OF FATHER Dominick Harron

11. BIRTHPLACE OF FATHER (State or Country) Ireland

12. MAIDEN NAME OF MOTHER Mary Gallagher

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mother M. Adelaide
(Address) St. Josephs Hospital Lewiston Idaho

15. Filed Jan 6 1921 Brian E. Bruen Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 24 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1919 to Dec 24 1920
that I last saw her alive on Dec 23 1920
and that death occurred on the date stated above, at 12 AM

The CAUSE OF DEATH* was as follows:
General Tuberculosis
of the Lungs
(Duration) 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Elmer G. Braddock M. D.
Dec 24 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Lewiston Ida. | DATE OF BURIAL 12/27/1920

20. UNDERTAKER | ADDRESS Lewiston Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
File No. 32674
Registered No. 5-69

1. PLACE OF DEATH
County of Nez Perce
City of Lapwai
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Kollenborn.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Feb. (Month) 15 (Day) 1871 (Year)

7. AGE: 49 Yrs. 10 Mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Domestic wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Lee Smith

11. BIRTHPLACE OF FATHER (State or Country): Not known.

12. MAIDEN NAME OF MOTHER: not known.

13. BIRTHPLACE OF MOTHER (State or Country): Not known.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C E Kollenborn
(Address)

15. Filed Jan 8 1921 Emma E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1920, to Dec 25th 1920, that I last saw h.. alive on Dec 25th 1920, and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(Duration) ..... Yrs. 1 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C L Lawson M. D.
1/6 1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gifford via Culdesac Ida — DATE OF BURIAL: 12/28 1920

20. UNDERTAKER: [illegible] — ADDRESS: Lewiston Ida.

Emb.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. ..... St.)

File No. 32675

Registered No. 570

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Julia Ann Lamar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 1 (Day) 1861 (Year)

7. AGE: 59 Yrs. 3 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Lucurgas Johnson

11. BIRTHPLACE OF FATHER (State or Country): Mis.

12. MAIDEN NAME OF MOTHER: Nancy Rotan

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daisy Lomax

(Address) Kamiah Idaho

15. Filed Jan 5 1921

Susan E. Bruce
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to Dec 25 1920 that I last saw h.. alive on Dec 25 1920 and that death occurred on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Paralytic stroke

Gen. Paralysis

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary) Cystic Ovary & Appendicitis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) E. K. White M. D.

Dec 26 1920 (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kamiah - Ida

DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Earl Boore

ADDRESS Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96 Nez Perce
Primary Registration District No. 1009
(No. 1 St. Joseph Hospital St.)

File No. 32676
Registered No. 571

1. PLACE OF DEATH

County of Nez Perce
City of Lewiston
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Theresa Emma Gesellchen

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	married

6. DATE OF BIRTH: Aug 15 (Month) (Day) 1865 (Year)

7. AGE: 55 Yrs. 4 Mos. 13 Ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wisconsin

10. NAME OF FATHER: August Wehig

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: - - -

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) P H Gesellchen
(Address) Spalding Idaho

15. Filed Jan 8 1921 Idaho
Local Registrar
Swan E Bauer

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920, to Dec 28 1920
that I last saw her alive on Dec 28 1920,
and that death occurred on the date stated above, at 10 A. M.
The CAUSE OF DEATH* was as follows:
Paralysis of intestines.

(Duration) ..... Yrs. ..... mos. 1 ds.
Contributory (Secondary) Hypostatic congestion
(Duration) ..... yrs. ..... mos. 8 ds.
(Signed) C J Corbin M. D.
19..... (Address) Lewiston Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston Ida
DATE OF BURIAL: 12/30 1920

20. UNDERTAKER
ADDRESS: Lewiston

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96 Johnson Corrected

Primary Registration District No. 6009

(No. ..... , ... St.)

File No. 32677

Registered No. 372

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Elizabeth Amanda Hellen

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: February (Month) 4 (Day) 1839 (Year)

7. AGE: 81 Yrs. 10 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: — Lyons

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. A. Weller

(Address) 16 St Clarkston

15. Filed Jan 5 1921 Susan E. Burns Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10 1920 to Dec 28 1920 that I last saw h.. alive on Dec 26 1920 and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. C. Cannon M. D.

1920 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kendrick Ida

DATE OF BURIAL: 1/3 1920

20. UNDERTAKER: Emil Brown

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Clarkston

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. **PLACE OF DEATH**

County of Nez Perce

City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 96

Primary Registration District No. 1009

(No. St. Joseph Hospital St.)

File No. 32678

Registered No. 873

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lena Klamman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	married

6. DATE OF BIRTH

(Month) (Day) (Year) 1846

7. AGE

54 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Germany

10. NAME OF FATHER Chris Voglemann

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER (State or Country) Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) O. D. Gravens

(Address) Giffords

15. Filed Jan 8 1921 Susan E. Bruce Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec (Month) 30th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 28th 1920, to Dec 30th 1920, that I last saw her alive on Dec 30th 1920, and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows:

Anuria

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Acute Nephritis

(Duration) yrs. mos. 4 ds.

(Signed) O. D. Gravens M. D.

1921 (Address) Lewiston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Reburn, Ida — DATE OF BURIAL 1/3/ 1921

20. UNDERTAKER Eppich Bros — ADDRESS Lewiston

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Ada
City of Meridian (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 26
Primary Registration District No. 2064

File No. 32681
Registered No. 39
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Josiah A Richardson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH: Sept (Month) 2 (Day) 1863 (Year)

7. AGE: 57 yrs. 3 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Utah

10. NAME OF FATHER Joseph Richardson

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Sarah A. Kingsbit

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ruth E Richardson
(Address) .....

15.
Filed Dec 1920 R T Mercer Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920 to Dec 3 1920
that I last saw h in alive on Dec 3 1920
and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Cancer of neck.

(Duration) 2 yrs. mos. ds.

Contributory (Secondary) Hemorrhage (Epistaxis)

(Duration) yrs. mos. 8 ds.

(Signed) R T Mercer M. D.

19 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Malad | DATE OF BURIAL: Dec 1920

20. UNDERTAKER: E. J. Benson | ADDRESS: Malad

SYMS - YORK CO., PTRS. & BDRS. 19760

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 1069

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32682

Registered No. 46

1. PLACE OF DEATH.
County of Oneida
City of Malad
If death occurs away from usual residence, give facts called for under special information.
(No. ....., ... St.)
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lillian Kent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child

6. DATE OF BIRTH: Nov (Month) 30 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. ..... ds.
IF LESS than 1 day how many ..4.. hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Brigham D Kent

11. BIRTHPLACE OF FATHER (State or Country): Malad

12. MAIDEN NAME OF MOTHER: Ethel Rose.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Brigham A. Kent.
(Address) Malad. Idaho.

15. Filed Jan 6 1921 B.O. Mann M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1919, to Dec 1920, that I last saw h[illegible] alive on Dec 1919, and that death occurred on the date stated above, at 4 M.

The CAUSE OF DEATH* was as follows:

Cranial injury at birth

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. F. Alton M. D.

12-2 1920 (Address) Malad

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasantview | DATE OF BURIAL: Dec 2 1920

20. UNDERTAKER: J. Guy Benson | ADDRESS: Malad Ida

SYMS - YORK CO., TRS. & SORS. 18760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 76

Primary Registration District No. 2064

File No. 32683

Registered No. 4

County of

City of (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Lucile Thorpe

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 19 (Day) 1920 (Year)

7. AGE: yrs. 2 mos. 28 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business, or dstablishment in which employed (or employer): Child

9. BIRTHPLACE (State or Country): Malad

10. NAME OF FATHER: Joseph Thorpe Jr

11. BIRTHPLACE OF FATHER (State or Country): Samoia Onondaga

12. MAIDEN NAME OF MOTHER: Lucy Davis

13. BIRTHPLACE OF MOTHER (State or Country): Samoia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. Thorpe Jr.

(Address) Malad Idaho

15. Filed Jan 6 1921 R. M. Maner M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1920 to Dec 13 1920 that I last saw h or alive on Dec 13 1920 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(Duration) yrs. mos. 16 ds.

Contributory (Secondary) Lobar Pneumonia

(Duration) yrs. mos. 3 ds.

(Signed) R. M. Maner M. D.

19 (Address) Malad, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Malad Idaho — DATE OF BURIAL: Dec. 18 1920

20. UNDERTAKER: J. Guy Dewsnup — ADDRESS: Malad Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6YMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 26

Primary Registration District No. 2069

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32684

Registered No. 42

1. PLACE OF DEATH

County of Oneida

City of Malad

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Rice

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: December 26 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 5 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Malad Idaho

10. NAME OF FATHER: Archie Rice

11. BIRTHPLACE OF FATHER (State or Country): Samaria Idaho

12. MAIDEN NAME OF MOTHER: Pearl Stuart

13. BIRTHPLACE OF MOTHER (State or Country): Minnesota

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Archie Rice

(Address) Malad Ida

15. Filed Jan 6 1921

R O Mauer M.D. Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 26 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 19 ..., to Dec 26 1920

that I last saw h..... alive on ..... 19...

and that death occurred on the date stated above, at 6:45 P. M.

The CAUSE OF DEATH* was as follows:

Stillborn Apparently due to premature labor

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

12-26-20 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Malad Ida — DATE OF BURIAL: Dec 27 1920

20. UNDERTAKER: D E Johnson — ADDRESS: Malad

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 5
Primary Registration District No. 1009
File No. 32685
Registered No. 13

1. PLACE OF DEATH.
County of Payette
City of New Plymouth
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Archibald H. Smedels

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. July (Month) 13 (Day) 1856 (Year)

7. AGE: 64 Yrs. 5 Mos. 5 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: retired Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Henry

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: Eliza

13. BIRTHPLACE OF MOTHER (State or Country): Not Known

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. A. H. Smedels
(Address) New Plymouth

15. Filed Dec 21 1920 — Wm J. Drysdale, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1920 to Dec 19 1920, that I last saw him alive on Dec 18 1920 and that death occured on the date stated above, at 3a M.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory (Secondary): Chronic Nephritis

(Duration ..... yrs. unknown mos. ..... ds.

(Signed) W. F. Drysdale M. D.

12-21-1920 (Address) New Plymouth Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New Plymouth Ida — DATE OF BURIAL: Dec 22 1920

20. UNDERTAKER: A Meyer — ADDRESS: New Plymouth

SYMS - YORK CO., PTRS. & BORS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

File No. 32686
Registered No. 48

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Hattie A Alspaugh

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
Dec (Month) 15 (Day) 1871 (Year)

7. AGE
49 yrs. 11 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Ind

10. NAME OF FATHER Anderson

11. BIRTHPLACE OF FATHER
(State or Country) Ind

12. MAIDEN NAME OF MOTHER Jennie Cottrell

13. BIRTHPLACE OF MOTHER
(State or Country) Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Hava Clevenger
(Address) Rupert Idaho.

15.
Filed Dec 10 1920 J. O Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Nov (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 12 1920 to Nov 29 1920 that I last saw h alive on Nov 25 1920 and that death occurred on the date stated above, at 10 A. M.

The CAUSE OF DEATH* was as follows:
Carcinoma of Liver

(Duration) yrs. 3 mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Willoughby M. D.
12/1 1920 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death .....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	12-2 1920

20. UNDERTAKER	ADDRESS
J N. Adair	Payette Ida

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ____, ____ St.)

File No. 32687
Registered No. 49
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Samuel A Applegate

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Sept (Month) 15 (Day) 1837 (Year)

7. AGE
83 yrs. 2 mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Retired Farmer
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Ind.

10. NAME OF FATHER Squire Applegate

11. BIRTHPLACE OF FATHER (State or Country) Ind

12. MAIDEN NAME OF MOTHER Martha Stark

13. BIRTHPLACE OF MOTHER (State or Country) Ill Ind.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Applegate
(Address) Meridy Idaho

15.
Filed Dec 13 1920 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
June (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1 1920 to June 12 1920 that I last saw h alive on June 1920 and that death occurred on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:
Epitheliomia of face
(Duration) 1 yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J R Woodward M. D.
12/13 1920 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Applegate Cemetery near Falk Ida	Dec 14 1920

20. UNDERTAKER	ADDRESS
D. N. Adair	Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & ENGRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.
County of Payette
City of Payette
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4
Primary Registration District No. 1008
(No. ....., ... St.)

File No. 32688
Registered No. 30
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Avadina E Summers

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Widowed

6. DATE OF BIRTH
Aug (Month) 13 (Day) 1852 (Year)

7. AGE
68 yrs. 4 mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER Daniel Dalton

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Nancy Emerine

13. BIRTHPLACE OF MOTHER (State or Country) Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C W Summers
(Address) Payette Ida

15.
Filed Dec 14 1920 J C Woodward
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1920, to Dec 13 1920, that I last saw h[illegible] alive on Dec 13 1920, and that death occurred on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
12/14 1920 (Address) Payette Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Ida
DATE OF BURIAL: Dec 15 1920

20. UNDERTAKER: E V Adair
ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 32689
Registered No. 37

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Stillborn unfamed C. L. Cazier
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Dec (Month) 16 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 0 hrs. or 10 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Payette Ida

10. NAME OF FATHER: C. L. Cazier

11. BIRTHPLACE OF FATHER (State or Country): Willow Creek Montana

12. MAIDEN NAME OF MOTHER: Laura Jensen

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) by C. L. Cazier
(Address) Payette Idaho

15. Filed Dec 16 1920 J. C. Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended ~~deceased~~ from December 16 1920 to Dec 16 1920 that I last saw h[e]r alive on Dec 16 1920 and that death occurred on the date stated above, at 9 P.M.
The CAUSE OF DEATH* was as follows:
Stillborn-asthenia

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) J. C. Woodward M. D.
Dec 16 1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho
DATE OF BURIAL: Dec 17 1920
20. UNDERTAKER: C. L. Cazier
ADDRESS: Payette Id

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008

File No. 3290
Registered No. 32

1. PLACE OF DEATH

County of
City of Ontario Ore (No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charley H Ensign

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1850 (Year)

7. AGE: 70 Yrs. 0 Mos. 18 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Jeremiah Ensign

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Charlotte Phelps Webster

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C F Ensign
(Address) Payette Ida

15. Filed Dec 19 1931 J C Woodward Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-16 1920, to 12-18 1920 that I last saw him alive on 12-18 1920. and that death occurred on the date stated above, at 8:20 P.M.

The CAUSE OF DEATH* was as follows:

Stock, Following Op. for Diphtheria Carbuncle

(Duration) ? Yrs. ? mos. ? ds.

Contributory (Secondary) Senility

(Duration) 2 yrs. 2 mos. 2 ds.

(Signed) J. F. McNaul M. D.

12-19-1931 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Ida	Dec 20 1920
20. UNDERTAKER: Glenn C Landon	ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Payette

City of Payette

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 4

Primary Registration District No. 1008

(No. ....., ... St.)

File No. 32691

Registered No. 33

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Thomas Rhoads

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 13 (Day) 1866 (Year)

7. AGE: 54 Yrs. 5 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Painter & Paper

(b) General nature of industry, business or establishment in which employed (or employer): Ranger & Carpenter work

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Thos. Rhoads

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER: Kate Bardanna

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Geo. T. Rhoads

(Address) Payette, Idaho

15. Filed Dec 21 1920 J C Woodward Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 19 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 8-14 1920 to 12-19 1920 that I last saw him alive on 12-19 1920 and that death occurred on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis Cardiac hypertrophy Chronic parenchymatous Nephritis & Chronic Pulmo Conj. of Liver

(Duration) 7 Yrs. 4 mos. 2 ds.

Contributory (Secondary) Lead poison

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. L. McDonald M. D.

12-19 1920 (Address) Payette Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Payette Idaho — DATE OF BURIAL: Dec 22 1920

20. UNDERTAKER: Glenn C Landon — ADDRESS: Payette Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 4
Primary Registration District No. 1008
File No. 32692
Registered No. 54

1. PLACE OF DEATH
County of Payette
City of Payette
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Washington Mondhorst
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, ~~MARRIED, WIDOWED OR DIVORCED~~: Single
(Write the word.)

6. DATE OF BIRTH: February (Month) 22 (Day) 1893 (Year)

7. AGE: 27 Yrs. 10 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farming
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: George Mondhorst

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Matilda Sievers

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Johanna Casburg
(Address) Payette Ida.

15. Filed Dec 24 1920 J. C. Woodward
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1917, to Dec 22 1920 that I last saw him alive on Dec 20 1920 and that death occurred on the date stated above, at 8 A.M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
12/23 1920 (Address) Payette Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Payette Idaho	Dec 23 1920
20. UNDERTAKER	**ADDRESS**
Glenn C Landon	Payette Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Power

City of Amer. Falls

Registration District No. 25

Primary Registration District No.

(No. ....., ... St.)

File No. 32693

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Wiens

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. Sept (Month) 27 (Day) 1870 (Year)

7. AGE: 30 Yrs. 2 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Samuel Witt

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Lydia Young

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) H. J. Wiens.

(Address) Amer. Falls Ida.

15. Filed Dec 18 1920. R. F. Nath. Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24653

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 25 1920, to Dec 9 1920, that I last saw her alive on Dec 8 1920, and that death occured on the date stated above, at 10 a. M.

The CAUSE OF DEATH* was as follows: Puerperal septicemia following child birth

(Duration) ..... Yrs. ..... mos. 16 ds.

Contributory (Secondary) Cerebral embolus

(Duration ..... yrs. ..... mos. 3 ds.

(Signed) C. F. Schultz M. D.

12/9 1920 (Address) Amer. Falls. Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Homestead Cemetery — DATE OF BURIAL: 12/12 1920

20. UNDERTAKER: Family — ADDRESS

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 2694
Registered No. 68

1. PLACE OF DEATH.
County of Shoshone
City of Mace

Registration District No. VV
Primary Registration District No. 7V00
(No. Residence St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Salo

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH: Jan (Month) 22 (Day) 1888 (Year)
7. AGE: 32 yrs. ..... mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Finland
10. NAME OF FATHER: J. Salo
11. BIRTHPLACE OF FATHER (State or Country): Finland
12. MAIDEN NAME OF MOTHER: ——
13. BIRTHPLACE OF MOTHER (State or Country): Finland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J. Salo
(Address) Mace Ida
15. Filed 11/22 1920 H. C. Mowary Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) 21 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1920, to Nov 19 1920
that I last saw h[illegible] alive on Nov 19 1920
and that death occurred on the date stated above, at 10:30 P M.
The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis
(Duration) 2 yrs. — mos. — ds.
Contributory (Secondary)
(Duration) ..... yrs ..... mos. ..... ds.
(Signed) Chas. A. Hellman M. D.
Nov 21 1920 (Address) Burke

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence: Mace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace Ida
DATE OF BURIAL: Nov 26 1920
20. UNDERTAKER: Harry Thompson
ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32695
Registered No. 59

1. PLACE OF DEATH.
County of Shoshone
City of Burke
Registration District No. 17 V
Primary Registration District No. 17 V 06
(No. Residence Burke 2da St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth E. Stick

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Sept (Month) 11 (Day) 1903 (Year)
7. AGE: 17 yrs. — mos. — ds. IF LESS than 1 day how many ..... hrs. or ..... min?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Student
(b) General nature of industry business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Michigan
10. NAME OF FATHER: Thomas Stick
11. BIRTHPLACE OF FATHER (State or Country): England
12. MAIDEN NAME OF MOTHER: Emily Skewes
13. BIRTHPLACE OF MOTHER (State or Country): Penn. U. S.
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Thomas Stick
(Address) Burke Ida
15. Filed 12/20 1920 W. E. Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 17 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Jan 1910, to Dec 17 1920
that I last saw her alive on Dec 17 1920
and that death occurred on the date stated above, at 9a M.
The CAUSE OF DEATH* was as follows:
Aortic Aneurysm
(Duration) 12 yrs. — mos. — ds.
Contributory (Secondary) Nephritis
(Duration) — yrs. — mos. — ds.
(Signed) Charles Stiles M. D.
Dec 17 1920 (Address) Burke Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?
Former or usual residence Burke 2da

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: Dec. 19 1920
20. UNDERTAKER: Harry Thompson ADDRESS: Wallace 2da

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32696
Registered No. 60

1. PLACE OF DEATH.
County of Shoshone
City of Mullan (No. Residence St.)

Registration District No. 12
Primary Registration District No. 1200

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Helmi Marie Freiting

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wh
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug. (Month) 8 (Day) 1919 (Year)

7. AGE: 1 yrs. 4 mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wallace Ida

10. NAME OF FATHER: Isaac Freiting

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Hilda Peterson

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Isaac Freiting
(Address) Mullan Ida

15. Filed 12/23 1920 H C Mowery Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20 1920, to Death 21/20 1920 that I last saw her alive on Dec 21 1920 and that death occurred on the date stated above, at 2:00 P. M.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia

(Duration) ..... yrs. ..... mos. 11 hours

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F W Ralfs M. D.

Dec 21 1920 (Address) Mullan Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 1 yrs. 4 mos. 12 ds. In the State 1 yrs. 4 mos. 12 ds.
Where was disease contracted, if not at place of death?
Former or usual residence Mullan Ida

19. PLACE OF BURIAL OR REMOVAL: Burial, — DATE OF BURIAL: Dec 24 1920

20. UNDERTAKER: Godfrey Thorfinnson ADDRESS: Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-12 M. 6-15-17.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 61
Registered No. 32697

1. PLACE OF DEATH
County of .....
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 12
Primary Registration District No. 1200
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Henry Erickson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
male	white	

6. DATE OF BIRTH.
..... (Month) ..... (Day) 1880 (Year)

7. AGE
40 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) Sweden

10. NAME OF FATHER —

11. BIRTHPLACE OF FATHER
(State or Country) —

12. MAIDEN NAME OF MOTHER —

13. BIRTHPLACE OF MOTHER
(State or Country) —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. R. Bean
(Address) Co. Physician

15. Filed 12/30/20 191.... H. C. Mowery Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 19 1920 to Dec 29 1920
that I last saw M. alive on Dec 28 1920
and that death occurred on the date stated above, at 7:30 p. M.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

4
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory .....
(Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) James R Bean M. D.
12/30 1920 (Address) Wallace Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Greenmont	Dec 31. 1920.
20. UNDERTAKER	ADDRESS
B. L. Hartell	Wallace

Dr. Lindsay

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. C.O.D. 2699
Registered No. .....

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 1173
Primary Registration District No. 7701
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carlo Edwin Kauppi

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Feb. (Month) 11 (Day) 1920 (Year)

7. AGE: Yrs. 8 Mos. 20 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Kauppi

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Fannie Lahe

13. BIRTHPLACE OF MOTHER (State or Country): Finnla nd

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Kauppi
(Address) Kellogg Ida

15. Filed 11/13 1920 Geo D Lester Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 15 1920 to Oct 31 1920 that I last saw him alive on Oct 31st 1920 and that death occurred on the date stated above, at 9 A. M.

The CAUSE OF DEATH* was as follows:

Empyaemia

(Duration) ... Yrs. ... mos. 2 ds.

Contributory (Secondary) Pneumonia

(Duration) ... Yrs. ... mos. ... ds.

(Signed) W. C. Lindsay M. D.

11/14 1920 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg Idaho — DATE OF BURIAL: Nov 2 1920

20. UNDERTAKER: M C Hamilton. — ADDRESS: Kellogg Ida

FORM V. S. No. 5-12 M. 6-15-17.

Mason

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32700
Registered No. 44

Registration District No. 123
Primary Registration District No. V.V.01
(No. ....., ... St.)

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Pauline Woodin

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug. (Month) 21 (Day) 916 (Year)

7. AGE: 4 Yrs. V Mos. VV ds.
IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington.

10. NAME OF FATHER: Arthur Woodin

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Lillian Thompson

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Woodin
(Address) 117 Elm St.

15. Filed 11/23 1920 Jas D Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 11th 1920 to Nov 13 1920
that I last saw her alive on Nov 13 1920
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Diphtheria
(Duration) [illegible] Yrs. mos. 3 ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) J. R. Mason M. D.
11/23 1920 (Address) Kellogg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Kellogg — DATE OF BURIAL: Nov. 13. 1920

20. UNDERTAKER: M. L. Thornhill — ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 4[illegible]701
Registered No. [illegible]

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 7701
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dugald T. McComb

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): ~~Married~~

6. DATE OF BIRTH: Aug. (Month) 15 (Day) 1854 (Year)

7. AGE: 66 Yrs. 3 Mos. 14 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Canada

10. NAME OF FATHER: John McComb

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Katherine Turner

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Effa Richardson
(Address): Kellogg Idaho

15.
Filed 11/30 1920
Geo. D. Lesher
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1 1920 to Nov 29 1920
that I last saw h[illegible] alive on Nov 28 1920
and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:
Typhoid fever
Valvular heart disease

(Duration) Yrs. 1 mos. ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) W. C. Lindsay M. D.
11/30 1920 (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Spokane Wash. DATE OF BURIAL: Nov 30 1920

20. UNDERTAKER: M. C. Thornhill ADDRESS: Kellogg, Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Copy

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 43
Registered No. 32702

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 123
Primary Registration District No. 2
(No. Victor Hotel, Mullan St.)

2. FULL NAME Frederick M Russell

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. January (Month) 12 (Day) 1868 (Year)

7. AGE 51 Yrs. 10 Mos. 25 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Assayer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John C Russell

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Angeline Osgood

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant):
(Address):

15. Filed 12/10 1920 Geo D Lesher
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec 7 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to ..... 191...
that I last saw h.....alive on ..... 191....
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Suicide
Cut throat
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Geo D Lesher M. D.
12-9-1920 (Address) Coroner Kellogg Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: New York City N.Y.
DATE OF BURIAL: 1920

20. UNDERTAKER: P C Worstell
ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

32705 Feb

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 46
Registered No. .....

Registration District No. 1273
Primary Registration District No. 7701

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fanny Mauthey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE Whit

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) Married

6. DATE OF BIRTH. Mar (Month) 19 (Day) 1853 (Year)

7. AGE 67 Yrs. 9 Mos. 1 ds.
IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) England

10. NAME OF FATHER John Taddan

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Mary Martin

13. BIRTHPLACE OF MOTHER (State or Country) England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Doorthey
(Address)

15. Filed 1/6 1921 Jno D Lesher Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1st 1920 to Dec 15 1920
that I last saw h.....alive on Dec 15 1920
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Carcinoma breast,
(Duration) 6 Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) Hbl Lindsay M. D.
1/5 1921 (Address) Kellogg Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Kellogg Idaho — **DATE OF BURIAL** Dec 23 1920

20. UNDERTAKER M. C. Thornhill — **ADDRESS**

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 123 — 32707 — File No. 45

Primary Registration District No. 7701

Registered No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone
City of Kellogg

2. FULL NAME Susan McRae

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1854 (Year)

7. AGE: 66 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: Archie McLuckie

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Susan McLuckie

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John McRae
(Address) Kellogg, Idaho

15. Filed 1/5 1921. Jos. S. Lesher, Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1920 to Dec 31 1920 that I last saw h~~e~~r alive on Dec 31 1920. and that death occurred on the date stated above, at 5. A. M.

The CAUSE OF DEATH* was as follows:

Cancer of Uterus

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) J. R. Mason M. D.

1/5 1921. (Address) Kellogg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the ,State....yrs.....mos....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg, Idaho — DATE OF BURIAL: Jan 7, 1921.

20. UNDERTAKER: McC. Thornhill — ADDRESS: Kellogg

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

Form V. S. No. 5. 12½M.7-24-11

CERTIFICATE OF DEATH

32708

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 43

Registered No.

1. PLACE OF DEATH.
County of Shoshone
City of Kellogg
(No. , St.)

Registration District No. 23
Primary Registration District No. 2301

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elaine Rudd

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX girl
4. COLOR OR RACE white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word) Single

6. DATE OF BIRTH Apr (Month) 2 (Day) 1920 (Year)

7. AGE yrs. mos. 8 ds. 10
IF LESS than 1 day how many ..... hrs. or ..... min?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Seattle, Wash.

10. NAME OF FATHER Edward Rudd

11. BIRTHPLACE OF FATHER (State or Country) Elgin, Ill.

12. MAIDEN NAME OF MOTHER Anna Stred

13. BIRTHPLACE OF MOTHER (State or Country) Milon Minn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr O Gray D.O.
(Address) Kellogg Idaho

15.
Filed 10/13 1920 Geo. D Lesher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH Dec (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1920, Dec 13 1920
that I last saw her alive on Dec 12 1920
and that death occurred on the date stated above, at 2.30 M.
The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) yrs. mos. 6 ds.
Contributory (Secondary) severe cold
(Duration) yrs. mos. 6 ds.

(Signed) Dr O Gray D.O. M. D.
Dec 13 1920 (Address) Kellogg Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds.
In the State ..... yrs ..... mos ..... ds.
Where was disease contracted, if not at place of death?.....
Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL Kellogg, Ida
DATE OF BURIAL 10/14 1920

20. UNDERTAKER M. C. Thornhill
ADDRESS Kellogg

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 17143

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

32709

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 3
Registered No. .....

Registration District No. 123
Primary Registration District No. 7701

1. PLACE OF DEATH
County of Shoshone
City of Kellogg
If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME George Massaw

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	Single	Single

6. DATE OF BIRTH. No information
(Month) (Day) (Year)

7. AGE about 6 oyear
.....Yrs.....Mos.....ds.

IF LESS than 1 day how many .... hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Miner
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE
(State or Country) No information

10. NAME OF FATHER No information

11. BIRTHPLACE OF FATHER
(State or Country) No information

12. MAIDEN NAME OF MOTHER No information

13. BIRTHPLACE OF MOTHER
(State or Country) No information

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15.
Filed 1/1.0 1911. Geo. D. Lesher
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Nov. 27 1910
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows:
Heart Disease
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) Geo. D. Lesher M. D.
1/1.0 1911. (Address) Kellogg Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Kellogg Idaho — DATE OF BURIAL Dec 6. 1910.

20. UNDERTAKER M C Chamberlin — ADDRESS Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 32710
Registered No. Two

1. PLACE OF DEATH
County of Teton
City of Driggs
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Delmar Earl Nickle
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Oct (Month) 25 (Day) 1920 (Year)

7. AGE: ..... Yrs. 1 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer): Infant

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Albert. Earl. Nickle

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: O. A. Campbell

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. E. Nickell
(Address) Driggs, Idaho.

15. Filed Jan 5th 1920 Martha Marker, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec- 5 - 1920., to Dec- 11 1920
that I last saw him alive on Dec- 9 - 1920
and that death occurred on the date stated above, at 1:20 A.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Whooping Cough.
(Duration) ..... yrs. 1 mos. ..... ds.

(Signed) A. A. Culbertson M. D.
Dec. 1920. (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rapin Cemetery — DATE OF BURIAL: Jan. Dec 11 1920

20. UNDERTAKER: L. O. Gilliam — ADDRESS: Driggs, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 32711
Registered No. One

1. PLACE OF DEATH
County of Fremont
City of Victor
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dolores Drake

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Strike out all but the proper word.)

6. DATE OF BIRTH: July (Month) 23 (Day) 1920 (Year)

7. AGE: Yrs. 5 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Victor Idg

10. NAME OF FATHER: Fred Drake Jr.

11. BIRTHPLACE OF FATHER (State or Country): Victor Idg

12. MAIDEN NAME OF MOTHER: Loraine Robertson

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Drake Jr.
(Address) Victor, Idg

15. Filed Jan 5th 1921 Martha Marker Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 4 1920 to Jan 4 1920
that I last saw her alive on Jan 4 1920
and that death occurred on the date stated above, at 8:20 P.M.
The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) [illegible] M. D.
Jan 5 1920 (Address) Victor Idg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cedron Idaho — DATE OF BURIAL: Jan 5 1921

20. UNDERTAKER — ADDRESS

A stillbirth must be registered both as a birth and a death. The date of death should be the date of delivery and the death certificate should further state, if known, the cause of the stillbirth and the period of utero gestation in months.

STATEMENT OF OCCUPATION.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer, Physician, Stenographer, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (*a*) the kind of work and also (*b*) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (*a*) *Spinner,* (*b*) *Cotton mill;* (*a*) *Salesman,* (*b*) *Grocery;* (*a*) *Foreman,* (*b*) *Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specifications, as *Day laborer, Farm laborer, Laborer—Coal mine,* etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers,* who receive a definite salary), may be entered as *Housewife, Housework,* or *At home,* and children, not gainfully employed, as *At school* or *At home.* If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None.*

STATEMENT OF CAUSE OF DEATH—Name, first the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid Pneumonia") *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum,* etc., *Carcinoma, Sarcoma,* etc., of .....(name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms; *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.; Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify as "PUERPERAL *septicemia,*" "PUERPERAL *peritonitis,*" etc., all diseases resulting from childbirth or miscarriage. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g. *sepsis, tetanus*) may be stated under the head of "Contributory."

2 #6

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 77
Primary Registration District No. 2176
File No. 32712
Registered No. Three

1. PLACE OF DEATH
County of Teton
City of Driggs
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Clemmins N. Fairbanks

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: Oct. (Month) 23 (Day) 1843 (Year)

7. AGE: 77 Yrs. 1 Mos. 29 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): Farmer

9. BIRTHPLACE (State or Country): N. J.

10. NAME OF FATHER: David Fairbanks

11. BIRTHPLACE OF FATHER (State or Country): State Vermont.

12. MAIDEN NAME OF MOTHER: Susan Manderville

13. BIRTHPLACE OF MOTHER (State or Country): N. J.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. B. Fairbanks
(Address) Driggs, Idaho.

15. Filed 12/22/1920 Martha Marker Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 18 1920, to Dec. 22 1920 that I last saw him alive on Dec. 21 1920 and that death occurred on the date stated above, at 1:20 A.M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. A. Culbertson M. D.
12-22 1920 (Address) Driggs Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Driggs, Idaho. DATE OF BURIAL: 12-24-20. 19

20. UNDERTAKER: W. J. King ADDRESS: Driggs, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
File No. 32713
Registered No. 1 D 22

1. PLACE OF DEATH
County of Twin Falls
City of Hansen
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elijah N. Spencer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Oct. (Month) 7 (Day) 1842 (Year)

7. AGE: 78 Yrs. 1 Mos. 24 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer (retired)
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: Jeremiah Spencer

11. BIRTHPLACE OF FATHER (State or Country): Don't Know

12. MAIDEN NAME OF MOTHER: Lotridge

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Bert Spencer
(Address): Hansen

15. Filed Dec 2 1920 — J. M. Davis, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 1st. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 12:40 a.m. P.M.

The CAUSE OF DEATH* was as follows:
Chronic valvular Heart disease

(Duration) 20 Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. J. Foreman Coroner
12/1 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls
DATE OF BURIAL: Dec. 3 1920

20. UNDERTAKER: J. J. Foreman
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 36
Primary Registration District No.
File No. 3274
Registered No. 23

1. PLACE OF DEATH

County of Twin Falls
City of ~~Twin Falls~~ Kimberly

If death occurs away from usual residence, give facts called for under special information.

(No. , St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME unnamed Giles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	W.	

6. DATE OF BIRTH: Dec. (Month) 9 (Day) 1920 (Year)

7. AGE: ....Yrs....Mos....ds.
IF LESS than 1 day how many....hrs. or 15 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idao

10. NAME OF FATHER Henry Giles

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Nettie Hanks

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Henry Giles
(Address) Kimberly, Idaho

15. Filed Dec. 10, 1920 J. M. Davis Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 9, (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 9, 1920 to Dec. 9, 1920 that I last saw her alive on Dec. 9 1920, and that death occurred on the date stated above, at 2:30 A.M.

The CAUSE OF DEATH* was as follows:

prematurity. 5 month x gestation

(Duration) ....Yrs....mos....ds.

Contributory (Secondary) polyhydramnios of mother

(Duration) ....yrs....mos....ds.

(Signed) J. M. Davis M. D.

12/10 1920 (Address) Kimberly, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
home	12/11, 1920
20. UNDERTAKER none	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls

City of Kimberly

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36

Primary Registration District No.

(No. , St.)

File No. 32715

Registered No. 24

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME unnamed Giles

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	W	S

6. DATE OF BIRTH: Dec. (Month) 9 (Day) 1920 (Year)

7. AGE: ...Yrs...Mos...ds. IF LESS than 1 day how many...hrs. or 10 min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER Henry Giles

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Nettie Hanks

13. BIRTHPLACE OF MOTHER (State or Country) Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Nettie Giles

(Address) Kimberly, Idaho

15. Filed Dec. 10, 1920

J. M. Davis — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 9, (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 9 1920 to Dec. 9 1920 that I last saw h... alive on Dec. 9 1920 and that death occurred on the date stated above, at 2:40 P.M.

The CAUSE OF DEATH* was as follows:

prematurity, 5 months plus gestation

(Duration) ...Yrs...mos...ds.

Contributory (Secondary) polyhydramnios of mother

(Duration) ...yrs...mos...ds.

(Signed) J. M. Davis M. D.

12/10 1920 (Address) Kimberly, Idho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death...yrs...mos...days. In the State...yrs...mos...days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
home	Dec. 11 1920
20. UNDERTAKER none	ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Dr Davis & Wilson

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of ... "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 36
Primary Registration District No.
(No. Twin Falls County Hospital)

File No. 32717
Registered No. 261

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Marie E Edmiston

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Mar 23 1890 (Month) (Day) (Year)

7. AGE: 30 Yrs. 9 Mos. 7 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: Joseph J. Diver

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Emma J. Irving

13. BIRTHPLACE OF MOTHER (State or Country): Wis.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) X Clyde E Edminster
(Address) Hansen Ida.

15. Filed Dec 30 1920 J. M. Davis Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 29 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-25 1920, to Dec 29 1920 that I last saw her alive on Dec 29 1920, and that death occurred on the date stated above, at 3.45 P. M.
The CAUSE OF DEATH* was as follows:

Puerperal Eclyptic pregnancy

(Duration) ... Yrs. ... mos. 5 ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. M. Davis M. D.
12/30 1920 (Address) Kimberly Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Wpo. | DATE OF BURIAL ... 19 ...

20. UNDERTAKER: T. J. Rossman | ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

Dr Van Cott

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of ' '
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. , St.)

File No. 2278
Registered No.

2. FULL NAME Fredrick Herman Schunger

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write word): Single

6. DATE OF BIRTH: Nov (Month) 30 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls.

10. NAME OF FATHER: H. C. Schunger

11. BIRTHPLACE OF FATHER (State or Country): Germany.

12. MAIDEN NAME OF MOTHER: Josephine E. Matthys

13. BIRTHPLACE OF MOTHER (State or Country): Holland.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. C. Schunger
(Address) Twin Falls Ida

15.
Filed Dec 2 1920
J. T. Chapman
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 2 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 30 1920, to Dec 2 1920, that I last saw h.im alive on Dec 1 1920, and that death occurred on the date stated above, at 3:25 A.M.

The CAUSE OF DEATH* was as follows:

Atelectassis Congenital

(Duration) 0 Yrs. 0 mos. 2 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) E. R. Van Cott, M. D.

12-2 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: Dec 2 1920

20. UNDERTAKER: P. J. Grossman
ADDRESS: Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
(No. ..... , ... St.)

File No. 32719
Registered No. .....

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kendall Marshall
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Single

6. DATE OF BIRTH
Oct (Month) 11 (Day) 1903 (Year)

7. AGE
17 Yrs. 2 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Fred Marshall

11. BIRTHPLACE OF FATHER (State or Country) England

12. MAIDEN NAME OF MOTHER Bellhenes Mary Gilbreth

13. BIRTHPLACE OF MOTHER (State or Country) Emerson Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Marshall
(Address) Carleton Ida

15. Filed Dec. 13. 1920. J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1920, to Dec 11 1920
that I last saw him alive on Dec 11 1920
and that death occurred on the date stated above, at 8:45 A.M.
The CAUSE OF DEATH* was as follows:
Meningitis
.....
.....
(Duration) ..... Yrs. ..... mos. 10 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) F. O. Dyer M. D.
Dec 13 1920 (Address) Twin Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Dec 13 1920

20. UNDERTAKER	ADDRESS
F. E. Wescott	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 32720
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Kimberly (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elvin Raymond Bruns
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June 30 1 (Month) (Day) (Year)

7. AGE: 11 Yrs. 5 Mos. 7 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: School Boy
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): S Dakota

10. NAME OF FATHER: Fred Bruns

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Hattie D cook

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred H. Bruns
(Address) Kimberly Idaho

15. Filed Dec. 9 1920
F. [illegible]
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 7 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 8, 1920 19 , to Nov. 29, 1920.
that I last saw h. alive on Nov. 29, 1920.
and that death occurred on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:
Chronic Parenchymatous Nephritis

(Duration) 2 Yrs. mos. ds.
Contributory (Secondary) Uraemia
(Duration) yrs. two weeks ds.

(Signed) William F. Passer, M. D.
Dec 9, 1920. (Address) Twin Falls, Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida — DATE OF BURIAL: Dec 9 1920

20. UNDERTAKER: [illegible] — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2 1 85
File No. 32721
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of ... (No. ..., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ralph Edward Terry

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 3 (Day) 1920 (Year)

7. AGE: Yrs. 6 Mos. 9 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Brigham Canyon, Utah

10. NAME OF FATHER Ivan B Terry

11. BIRTHPLACE OF FATHER (State or Country) Utah

12. MAIDEN NAME OF MOTHER Margrite L Nichols

13. BIRTHPLACE OF MOTHER (State or Country) Colorado

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ivan B Terry
(Address) Shoshone Ida

15. Reg No 82
Filed Dec 13 1920
J. P. Rountree
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1920 to Dec 12 1920 that I last saw h.m alive on Dec 11 1920, and that death occurred on the date stated above, at 9a M.
The CAUSE OF DEATH* was as follows:

Intussusception
(intussusception)
(Duration) ... Yrs. ... mos. 12 hrs.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) J M Day M. D.
Dec 12 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Shoshone Ida — DATE OF BURIAL ... 19...

20. UNDERTAKER: P. J. Grossman — ADDRESS Twin Falls Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 31

County of Twin Falls

Primary Registration District No. 2085

File No. 32722

City of .....

(No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. W. A. Grieve

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (write the word.)

6. DATE OF BIRTH: Nov. (Month) 14th (Day) 1887 (Year)

7. AGE: Yrs. 32 Mos. 10 ds. 28

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Mother and Home

(b) General nature of industry, business, or establishment in which employed (or employer): [redacted]

9. BIRTHPLACE (State or Country): Nebraska

10. NAME OF FATHER: Samuel H Collins

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Estella Verlina Coyer

13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) W. A. Grieve

(Address) Filer Ida

15. Filed Nov 22 19[illegible]

J. F. Ramsey Jr.
Local Registrar

SYMS - YORK CO., PTRS. & STRS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 6 1920, to Oct 12 1920, that I last saw h[illegible] alive on Oct 12 1920 and that death occured on the date stated above, at 8:35 A.M.

The CAUSE OF DEATH* was as follows:

Septicaemia

(Duration) ..... Yrs. ..... mos. 10 ds.

Contributory (Secondary) Confinement Oct. 8 Infected hand Oct 2

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank A. Dwight M. D.

19..... (Address) Filer, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls — DATE OF BURIAL: Oct 12 1920

20. UNDERTAKER: J. F. Grosman — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 27

Primary Registration District No. 2085

(No. ..... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32724

Registered No. .....

1. PLACE OF DEATH

County of Jerome

City of Eden

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ray Patton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Single

6. DATE OF BIRTH: May (Month) 20 (Day) 1920 (Year)

7. AGE: Yrs. 5 Mos. 23 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: T. H. Patton

11. BIRTHPLACE OF FATHER (State or Country): Ark.

12. MAIDEN NAME OF MOTHER: Myrtle Giles

13. BIRTHPLACE OF MOTHER (State or Country): Ark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) T. H. Patton

(Address) Eden Idaho

15. Filed Nov. 15 1920

J. F. Loughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 12 1920, to Nov 13 1920, that I last saw him alive on Nov 13 1920, and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(Duration) ..... Yrs. ..... mos. 2 ds.

Contributory .....
(Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. P. Scroggs M. D.

19..... (Address) Eden Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Nov. 14 1920
20. UNDERTAKER	ADDRESS
J. P. Grosvenor	Twin Falls

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 32725
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of [illegible]
If death occurs away from usual residence, give facts called for under special information.
(No. [illegible], [illegible] St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Teresa Bent

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: April (Month) 27 (Day) 1885 (Year)

7. AGE: 35 Yrs. 6 Mos. 12 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Penn.

10. NAME OF FATHER: George Lower

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER: Harriott Strickland

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) C. H. Bent
(Address) Kimberly Ida.

15. Filed Nov. 15. 1920 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: November (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 11:48 P.M.

The CAUSE OF DEATH* was as follows:
Bichloride of Mercury Poisoning Administered by herself with Suicidal intent.
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) S. J. Grossman Coroner
11/11 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: Nov. 14 1920

20. UNDERTAKER: S. J. Grossman | ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 32726
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie L Sawyer
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Mar 6 1845
(Month) (Day) (Year)

7. AGE: 45 Yrs. 8 Mos. 19 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Wis

10. NAME OF FATHER: John Trenhaile

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Elizabeth Arthur

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Albert Sawyer
(Address):

15. Filed Nov 27 1920 J. F. Gaughlin
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov 23 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 23 1920 to Nov 23 1920
that I last saw her alive on Nov 23 1920
and that death occurred on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:
Acute Obstruction of bowels

(Duration) Yrs. mos. 4 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) A W Wilson M. D.
Nov 23 1920 (Address) Twin Falls, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Idaho
DATE OF BURIAL: Nov. 27. 1920

20. UNDERTAKER: L E Wurtz
ADDRESS: Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 4085.
File No. 32727
Registered No.

1. PLACE OF DEATH

County of Twin Falls
City of Twin Falls
(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ernest Ellsworth Kelsey

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widower

6. DATE OF BIRTH June (Month) 5 (Day) 1878 (Year)

7. AGE 42 Yrs. 11 Mos. 30 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Garageman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) New Haven Conn.

10. NAME OF FATHER Egbert Kelsey.

11. BIRTHPLACE OF FATHER (State or Country) New Haven Conn.

12. MAIDEN NAME OF MOTHER Margaret E. Hinchliff

13. BIRTHPLACE OF MOTHER (State or Country) Randolph Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Louise D. Kelsey
(Address) 318 Bell Ave. West

15. Filed Nov 18 1920 J. F. Loughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov. (Month) 7 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 1:45 P.M.

The CAUSE OF DEATH* was as follows: Gun Shot Wound; [redacted] Homicidal

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. J. Grossman Coroner

11/8 1920 (Address) Twin Falls

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Twin Falls	Nov. 12 1920

20. UNDERTAKER	ADDRESS
J. J. Grossman	Twin Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2000
File No. 32728
Registered No.

1. PLACE OF DEATH
County of Lemhi
City of Eden
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Aberdeen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: July (Month) 24 (Day) 1 (Year)

7. AGE: 89 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Scotland

10. NAME OF FATHER: not known

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: not known

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Geo W Phillips
(Address) Eden Idaho

15. Filed Dec 5 1920
J H Loughlin
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 1 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10/20 1920 to 12/1 1920 that I last saw h[illegible] alive on 12/1 1920, and that death occurred on the date stated above, at 4 A.M.
The CAUSE OF DEATH* was as follows:
Senility
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) W. P. Scruggs M. D.
19 (Address) Eden Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Iron Hill
DATE OF BURIAL: Dec 5 1920

20. UNDERTAKER: J E Ward
ADDRESS: Ironfield

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

Dr Pike

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 2085
File No. 32729
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Delp

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: ~~Single~~ (Strike out wrong word.)

6. DATE OF BIRTH: Dec. 23rd 1920 (Month) (Day) (Year)

7. AGE: ... Yrs. ... Mos. 1 Ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls, Ida

10. NAME OF FATHER: K. W. Delp

11. BIRTHPLACE OF FATHER (State or Country): N. C.

12. MAIDEN NAME OF MOTHER: Victoria R. Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Vir.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) K. W. Delp
(Address) Filer Ida

15. Filed Jan 6. 1921 J. A. Coughlin Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. 24 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1920 to Dec 24 1920 that I last saw her alive on Dec. 24 1920 and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:
Congenital malformation of Heart.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) C. D. Weaver M. D.
19... (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Filer Idaho — DATE OF BURIAL: Dec 26 1920

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 32730
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm Sereday.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Not Known (Month) (Day) 1 (Year)

7. AGE: About 40 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheepherder.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Pa.

10. NAME OF FATHER: ~~Not~~ Thomas Sereday

11. BIRTHPLACE OF FATHER (State or Country): Not Known

12. MAIDEN NAME OF MOTHER: "

13. BIRTHPLACE OF MOTHER (State or Country): "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) County Hospital Records
(Address) Twin Falls Ida

15. Filed Dec 17 1920 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 26 1920, to Nov 30 1920, that I last saw him alive on Nov 30 1920, and that death occurred on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:
Acute dilatation of heart.

(Duration) Yrs. mos. 14 ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Hal Bieler, M. D.
Dec 15 1920 (Address) Twin Falls, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls | DATE OF BURIAL: Dec 4 1920

20. UNDERTAKER: R. J. Graesman | ADDRESS: Twin Falls Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32731
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of
(No. , St.)
Registration District No. 37
Primary Registration District No. 1065
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James Rael Tucker
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	White	Infant

6. DATE OF BIRTH
Dec 30 1920
(Month) (Day) (Year)

7. AGE
Yrs. Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Infant
(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Idaho

10. NAME OF FATHER James M Tucker

11. BIRTHPLACE OF FATHER (State or Country) Ocer

12. MAIDEN NAME OF MOTHER Lulia Rael

13. BIRTHPLACE OF MOTHER (State or Country) Ky

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J M Tucker
(Address)

15. Filed Dec. 3- 1921 J. F. Coughlin Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 30 1926
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/30/1920, to 1/2/1920, that I last saw h[illegible] alive on 12/30/1920, and that death occurred on the date stated above, at 5- PM.

The CAUSE OF DEATH* was as follows:
Marasmus

(Duration) Yrs. mos. 3 ds.
Contributory (Secondary) Premature birth

(Duration) yrs. mos. ds.

(Signed) W. G. [illegible] M. D.
12/3/1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL Twin Falls Idaho — DATE OF BURIAL 12-3 1920

20. UNDERTAKER* L E Wood — ADDRESS Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 37
Primary Registration District No. 1085
File No. 32732
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of " "
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME R. L. Rice

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6. DATE OF BIRTH: Oct 20 (Month) (Day) 1858 (Year)

7. AGE: 67 Yrs. 2 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Salt Lake City Utah

10. NAME OF FATHER: Leonard Rice

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Buckwalter

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs Mary Beeston
(Address): Rupert Idaho

15. Filed Dec. 27 19.. J. F. Gaughan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 20 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 – 1920, to Dec 20 1920, that I last saw h.. alive on Dec 1920, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:

Acute Uremia –

(Duration) Yrs. mos. 1 ds.
Contributory (Secondary) Arteriosclerosis
(Duration) yrs. ? mos. ds.

(Signed) S D [illegible] M. D.
12/23 1920 (Address) Twin Falls Idg

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Idg — DATE OF BURIAL: 12-22 1920

20. UNDERTAKER: P. J. Grossman — ADDRESS: Twin Falls Idg

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Twin Falls — Registration District No. 37

City of ..... — Primary Registration District No. 7 C 85

(No. ..... St.) — File No. 32732

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Louise Bentrup

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
female	white	Single

6. DATE OF BIRTH: Jan (Month) 6 (Day) 1880 (Year)

7. AGE: 40 Yrs. 11 Mos. 23 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Henry Bentrup

11. BIRTHPLACE OF FATHER (State or Country) Germany

12. MAIDEN NAME OF MOTHER Sophia Darda

13. BIRTHPLACE OF MOTHER (State or Country) Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W B Dierksen
(Address) Clover Idaho

15. Filed Dec. 29. 1920 — Dr J. F. Coughlin, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec-1 1920, to Dec. 29 1920, that I last saw her alive on Dec. 29 1920, and that death occurred on the date stated above, at 8 45 P.M.

The CAUSE OF DEATH* was as follows:
Osteomyelitis right femur

(Duration) 28 Yrs. — mos. — ds.

Contributory (Secondary) Post operative shock

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) H Wilson M.D. for C. F. McClintock M. D.

Dec 30 1920 (Address) Buhl, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Sylvan Grove	..... 19.....

20. UNDERTAKER: E Everett Allen — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

Dr Alexander

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of " "
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 37
Primary Registration District No. 1085
(No. ..... St.)

File No. 32734
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Eddy

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 25th 1920 (Month) (Day) (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Twin Falls Ida

10. NAME OF FATHER: G. R. Eddy.

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Blanche E. King.

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) x Geo. R. Eddy.
(Address) .....

15. Filed Dec. 27 1920
J. F. Grossman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 25th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 25 1920, to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Born Dead
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory .....
(Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Duncan A. Brown M. D.
12/26 1920 (Address) Twin Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Twin Falls Ida
DATE OF BURIAL: Dec 26 1920

20. UNDERTAKER: J. J. Grossman
ADDRESS: Twin Falls Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 38
Primary Registration District No. 2086
File No. 32735
Registered No.

1. PLACE OF DEATH.
County of
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Shirk

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widow

6. DATE OF BIRTH: Jan (Month) 17 (Day) 1837 (Year)

7. AGE: 82 yrs. 10 mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry business, or dstablishment in which employed (or employer): Wife

9. BIRTHPLACE (State or Country): Penn

10. NAME OF FATHER: Henry Engle

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Hanna Myers

13. BIRTHPLACE OF MOTHER (State or Country): Penn

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Mrs D L Gray Sis
(Address): Filer Ida

15. Filed Jan 9 20 191 A. A Newberry Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 7 (Day) 12-30 Pm 20 191 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to Dec 7 20 191..., that I last saw h[er] ~~alive~~ on ..... 191..., and that death occurred on the date stated above, at noon M.

The CAUSE OF DEATH* was as follows:

Senility
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary) Acute Indigestion
(Duration) ..... yrs. ..... mos. 2 hrs. ds.

(Signed) Frank A Dwight M. D.
Feb 19 20 (Address) Filer

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Abolene Kas
DATE OF BURIAL ..... 191...

20. UNDERTAKER
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 38

Primary Registration District No. 7086

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32736
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH

County of Twin Falls

City of Filer

If death occurs away from usual residence, give facts called for under special information.

(No. ..... St.)

2. FULL NAME Robert N. Bigham

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Widower

6. DATE OF BIRTH. Dec (Month) 1 (Day) 1836 (Year)

7. AGE 84 Yrs. — Mos. 8 ds.

IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) Farmers

9. BIRTHPLACE (State or Country) Platte Co, Missouri

10. NAME OF FATHER John Bigham

11. BIRTHPLACE OF FATHER (State or Country) Missouri

12. MAIDEN NAME OF MOTHER Sarah Evans

13. BIRTHPLACE OF MOTHER (State or Country) Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Wm. Price

(Address) Filer

15. Filed Dec 10 20 191.... A. A. Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 20 191.... to Dec 9 20 191...

that I last saw him alive on Dec 9 20 191...

and that death occurred on the date stated above, at 10 M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Nephritis

.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....

.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) A. A. Newberry M. D.

Dec 9 20 19.... (Address) Filer Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs.....mos....days. In the State....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
I.O.O.F. Cemet Filer	Dec 11. 191...

20. UNDERTAKER	ADDRESS
E C Drake	Filer

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32737
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

Registration District No. .....
Primary Registration District No. 7086
(No. ....., ... St.)

1. PLACE OF DEATH
County of Twin Falls
City of Filer
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME William MaCaw

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 24 (Day) 1844 (Year)

7. AGE: 76 Yrs. 10 Mos. 7 ds.
IF LESS than 1 day how many .... hrs. or ..... min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

9. BIRTHPLACE (State or Country) Ohio

10. NAME OF FATHER William MaCaw

11. BIRTHPLACE OF FATHER (State or Country) Ohio

12. MAIDEN NAME OF MOTHER Cannot be supplied

13. BIRTHPLACE OF MOTHER (State or Country) " " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Adaline MaCaw
(Address) Filer

15. Filed Dec 17 20 1920 A. A Newberry Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 1-5 PM
Dec (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 1920 to Dec 15 1920
that I last saw him alive on Dec 15 1920
and that death occurred on the date stated above, at 1.05 P.M.

The CAUSE OF DEATH* was as follows:
Arterio Sclerosis
Cerebral Hemorrhage
(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
Dec 17 1920 (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: T & F Cemetery — DATE OF BURIAL: Dec 18 1920

20. UNDERTAKER: E Drake — ADDRESS: Filer

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of .....
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 38
Primary Registration District No. 2086
(No. ....., ... St.)

File No. 32738
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Edward Hoodle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word): Married

6. DATE OF BIRTH. March 5 1849
(Month) (Day) (Year)

7. AGE: 71 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many .... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): N Carolina

10. NAME OF FATHER: Benjamin Hoodle

11. BIRTHPLACE OF FATHER (State or Country): N Carolina

12. MAIDEN NAME OF MOTHER: Sarah Mogner

13. BIRTHPLACE OF MOTHER (State or Country): N Carolina

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. H. Lancaster
(Address) Filer Idaho

15. Filed Dec 28 20 191.... G. A. Newberry
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec 26 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 1920 to Dec 25 1920
that I last saw him alive on Dec 25 1920
and that death occurred on the date stated above, at 6 ..... M.

The CAUSE OF DEATH* was as follows:
Arteria Sclerosis
Cerebral Hemorrhage
.....
.....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) A. A. Newberry M. D.
.....19.... (Address) Filer Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs. ....mos. ....days. In the State ....yrs. ....mos. ....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Filer Idaho — DATE OF BURIAL: Dec 29 1920

20. UNDERTAKER: F E Newell — ADDRESS: Twin Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-10.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2087
File No. 32739
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Eddie King.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec (Month) 6 (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 2 ds.
IF LESS than 1 day how many 4 hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Buhl

10. NAME OF FATHER: Dewey King

11. BIRTHPLACE OF FATHER (State or Country): Tenn.

12. MAIDEN NAME OF MOTHER: Elvia Hart

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dewey King
(Address) —

15. Filed Dec 8 1920 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 6 1920, to Dec 8 1920
that I last saw him alive on Dec 7 1920
and that death occurred on the date stated above, at 5 P M.
The CAUSE OF DEATH* was as follows:
Premature birth.
(Duration) ... Yrs. ... mos. ... ds.
Contributory (Secondary) ...
(Duration) ... yrs. ... mos. ... ds.
(Signed) J. H. Murphy M. D.
12-8 1920 (Address) Buhl.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death? ...
Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Buhl Cemetery.	12/9 1920
20. UNDERTAKER	ADDRESS
Neville & Legg	Buhl Ida.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 39
Primary Registration District No. 2087
(No. ..... St.)

File No. 32740
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Celia Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Dec 23. 1838 (Month) (Day) (Year)

7. AGE: 81 Yrs. 11 Mos. 17 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: Geo. Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Celia Olsan

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. A. Johnson
(Address) .....

15.
Filed 12-11 1920 J. T. Murphy
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1920, to Dec 10 1920, that I last saw h. alive on Dec 9 1920, and that death occurred on the date stated above, at 4 A M.
The CAUSE OF DEATH* was as follows:
Bowel obstruction
.....
.....
(Duration) ..... Yrs. ..... mos. 8 ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) A. H. C. Cusky M. D.
12/10/1920 (Address) Buhl Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Ida
DATE OF BURIAL: Dec 12 1920

20. UNDERTAKER: Homer B Evans
ADDRESS: Buhl

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 7087
File No. 32741
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Twin Falls (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John George Lutz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Apr (Month) 23 (Day) 1857 (Year)

7. AGE: 63 Yrs. 7 Mos. 3 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rekin Ill

10. NAME OF FATHER: Fred Lutz

11. BIRTHPLACE OF FATHER (State or Country): Hessen Germany

12. MAIDEN NAME OF MOTHER: Mary Kunkel.

13. BIRTHPLACE OF MOTHER (State or Country): Hessen Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Caroline Lutz
(Address) Burke

15. Filed Nov. 28 1920 J. W. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/8 1920 to 11/27 1920 that I last saw h[illegible] alive on 11/27 1920 and that death occurred on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Perforation of Gastric Ulcer Hemorrhage of 12 hrs duration

(Duration) Yrs. mos. ds.

Contributory (Secondary) Chronic Gastric Ulcer

(Duration) 2 yrs. mos. ds.

(Signed) [illegible] M. D.

11/30 1920 (Address) Burke Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Clover Ida — DATE OF BURIAL: Nov 30 1920

20. UNDERTAKER: Homer B Evans — ADDRESS: Burke Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 39
Primary Registration District No. 2081
File No. 32742
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Burke
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Barr Gilmour
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Divorced
6. DATE OF BIRTH: Sept (Month) 21 (Day) 1850 (Year)
7. AGE: 70 Yrs. 3 Mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Scotland
10. NAME OF FATHER: Alexander Gilmour
11. BIRTHPLACE OF FATHER (State or Country): Scotland
12. MAIDEN NAME OF MOTHER: Susan Barr
13. BIRTHPLACE OF MOTHER (State or Country): Scotland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Earl Samuels
(Address) Burke Ida
15. Filed 12-31 1920 J. H. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 30 (Day) 1920- (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/29 1920, to 12/30 1920, that I last saw h[illegible] alive on 12/29 1920, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Chronic Interstitial Nephritis

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) J. F. Curtis M. D.

12/31 1920 (Address) Burke Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Dayton Washington — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Homer B Evans — ADDRESS Burke

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 34
Primary Registration District No. 2087
File No. 32743
Registered No.

1. PLACE OF DEATH
County of Twin Falls
City of Buhl
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Thomas Leslie Royse
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state 'CAUSE OF DEATH' in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Mal.

4. COLOR OR RACE: Wht.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): M

6. DATE OF BIRTH: Dec (Month) 24 (Day) 1920 (Year)

7. AGE: V Yrs. V Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: V
(b) General nature of industry, business or establishment in which employed (or employer): V

9. BIRTHPLACE (State or Country)

10. NAME OF FATHER: Lorex Royse

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Susie Martin

13. BIRTHPLACE OF MOTHER (State or Country): Mo.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Alf Kimbrough
(Address) .....

15. Filed 1-7 1920 J. W. Murphy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) - 31 (Day) - 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-24-1920, to 12-31-1920, that I last saw h[illegible] alive on 12-31-1920, and that death occurred on the date stated above, at 11 P. M.
The CAUSE OF DEATH* was as follows:

Examination

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Geo J Fenning M. D.
1-1 1921 (Address) Buhl, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Buhl Cemetery — DATE OF BURIAL: 1-3 1921

20. UNDERTAKER: Newell D Pugh — ADDRESS: Buhl Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Marshall.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 32744
Registered No. /

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Katie Alice Millick

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: June (Month) 1 (Day) 1883 (Year)

7. AGE: 37 Yrs. 6 Mos. 1 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Edward Morrison

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Etta Slack

13. BIRTHPLACE OF MOTHER (State or Country): Mich.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Morrison
(Address) Weiser Idaho

15. Filed Dec 4th 1920 — W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 2 (Day) 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 2 19 20 to Dec 2 19 20
that I last saw h. alive on Dec 2 19 20
and that death occurred on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:

Peritonitis

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. D. McCracken M. D.
Dec 4 19 20 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 12-5 1920

20. UNDERTAKER: Northam McCann — ADDRESS: Weiser Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 1010
File No. 32745
Registered No. 2

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lena M. Keithley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: Wht
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1899 (Year)

7. AGE: 21 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Oregon

10. NAME OF FATHER: Edgar Reese

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Libby M. Downs

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. Keithley
(Address) Weiser Ida

15. Filed Dec 7 1920 M. R. Hamilton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 5 1920 to Dec 6 1920 that I last saw her alive on Dec 6 1920, and that death occurred on the date stated above, at 2 P. M.
The CAUSE OF DEATH* was as follows:

Acute Dilatation Heart.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D. W. Scammahorn M. D.
Dec 6 1920 (Address) Weiser

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Medrole Idaho
DATE OF BURIAL 1920

20. UNDERTAKER: Northcutt & McCann
ADDRESS: Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Washington

City of Weiser

Registration District No. 86

Primary Registration District No. 1010

(No. ..... St.)

File No. 32746

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred L. Taylor

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Sept (Month) 6 (Day) 1872 (Year)

7. AGE: 48 Yrs. 2 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Solomon McTaylor

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: Mary Suter

13. BIRTHPLACE OF MOTHER (State or Country): Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chester L. Taylor

(Address) Weiser, Idaho

15. Filed Dec 11th 1920 — W. R. Hamilton, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 10th 1920, to Dec 10th 1920, that I last saw h[illegible] alive on ..... 19....., and that death occurred on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Pneumonia -

Patient died just a few minutes before my arrival.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. R. Hamilton M. D.

Dec 11th 1920 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Hillcrest Cemetery — DATE OF BURIAL: 12/14 1920

20. UNDERTAKER: Northam & McEwen — ADDRESS: Weiser, Ida

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 56
Primary Registration District No. 2112
File No. 32747
Registered No. 4

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME George Herbert Shaw
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 16 (Day) 1919 (Year)

7. AGE: 1 Yrs. 5 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida

10. NAME OF FATHER: Peter Shaw

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Luenda Lee

13. BIRTHPLACE OF MOTHER (State or Country): Texas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pete Shaw
(Address) Weiser Idaho

15. Filed Dec 15 1920 W R Hamilton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) - 13 (Day) - 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/10 1920 to 12/13 1920, that I last saw him alive on 12/13 1920, and that death occurred on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis

(Duration) Yrs. ..... mos. 4 ds.

Contributory (Secondary) Bronchialitis

(Duration) ..... yrs. ..... mos. 15 ds.

(Signed) Ernest O. Friesen M. D.

12-15 1920 (Address) Weiser Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Fullerton Cemetery — DATE OF BURIAL: 12-14 1920

20. UNDERTAKER: Markham & McCain — ADDRESS: Weiser

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32748

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 8 6
Primary Registration District No. 2112
File No. 32748
Registered No. 5

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME John Lewis Gunsalt

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Widowed

6. DATE OF BIRTH: Nov (Month) 8 (Day) 1849 (Year)

7. AGE: 81 Yrs. 1 Mos. 10 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: ———

11. BIRTHPLACE OF FATHER (State or Country): Mo

12. MAIDEN NAME OF MOTHER: ———

13. BIRTHPLACE OF MOTHER (State or Country): ———

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. F. Gunsalt
(Address) Weiser Ida

15. Filed Dec 20th 1920 — W R Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

32748

16. DATE OF DEATH: Dec (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..., to ..... 19...,
that I last saw h..... alive on ..... 19...,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Senility died before Medical Assistance could arrive.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) L. B. Northam Coroner M. D.
12/20 1920 (Address) Weiser Idaho

*State the Disease Causing Death or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Hellogar Cemetery	12/20 1920
20. UNDERTAKER	ADDRESS
Northam Mortuary	Weiser Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 124
Primary Registration District No. 2202
File No. 3R756
Registered No. 29

1. PLACE OF DEATH

County of Ada
City of Kuna R (No. #1 ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Beulah Francis Buselman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Fem	White	

6. DATE OF BIRTH: Aug (Month) 28 (Day) 1858 (Year)

7. AGE: 62 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: L. C. Ashley

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: — —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. Lee Buselman
(Address) Kuna Ida

15. Filed Jan. 12 1921
Rue Bowers
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 11 1920, to Dec 21 1920
that I last saw h[illegible] alive on Dec 21 1920
and that death occurred on the date stated above, at 8:30 P. M.

The CAUSE OF DEATH* was as follows:
Pneumonia & both lungs

(Duration) ..... Yrs. ..... mos. 13 ds.

Contributory (Secondary) —

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. J. Coleman M. D.
12-22-1920 (Address) Kuna Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Kuna Ida	1 ..... 19 .....
20. UNDERTAKER	**ADDRESS**
H. Robinson	Nampa Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

C

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32757

Registered No. 1

If death occurred in a hospital, institution or camp give its NAME instead of street and number.

1. PLACE OF DEATH.
County of Ada
City of Boise
If death occurs away from usual residence, give facts called for under special information.

Registration District No.
Primary Registration District No.
(No. R. W. 4 St.)

2. FULL NAME Robert Jackson Floyd

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: 1 Jan (Month) 21 (Day) 18 (Year)

7. AGE: 2 yrs. 10 mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: W. S. Floyd

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Harriet A. Floyd

13. BIRTHPLACE OF MOTHER (State or Country): Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): W. S. Floyd
(Address): Boise R4

15. Filed 2-8 1921 H. F. Neal Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 4-1920 191 , to Dec. 14 1920 that I last saw him alive on Dec 14 1920 ; and that death occurred on the date stated above, at 10:30 P.M.

The CAUSE OF DEATH* was as follows:
Croup - Bronchial pneumonia

(Duration) yrs. mos. 1 ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) H. F. Neal M. D.
12-15 1920 (Address) Meridian

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... ds. In the State ..... yrs ..... mos ..... ds.
Where was Disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF ~~BURIAL~~ OR REMOVAL: Ellensburg Wash. DATE OF BURIAL: D. 191

20. UNDERTAKER: W S Mateer ADDRESS: Meridian Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 16672

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

32759

1. PLACE OF DEATH

County of Ada

City of Meridian

If death occurs away from usual residence, give facts called for under special information.

Registration District No.....

Primary Registration District No.....

(No....., ... St.)

File No.....

Registered No. 3

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Carolyn May Coleman

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	

6. DATE OF BIRTH: May (Month) 23 (Day) 1919 (Year)

7. AGE: 1 Yrs. 6 Mos. 27 ds.

IF LESS than 1 day how many..... hrs. or..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Meridian Idaho

10. NAME OF FATHER Bert Coleman

11. BIRTHPLACE OF FATHER (State or Country) Iowa

12. MAIDEN NAME OF MOTHER Maya Bingman

13. BIRTHPLACE OF MOTHER (State or Country) Washington

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. C. C. Burghduff

(Address) 2[illegible] 1 St. Portland Ore.

15. Filed 12-21 1920 H. F. Neal Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 20 1920, to Dec. 20 1920, that I last saw her alive on Dec. 20 1920 and that death occurred on the date stated above, at .....M.

The CAUSE OF DEATH* was as follows: Mitral regurgitation

(Duration) 1 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Rheumatism

(Duration) 2 yrs. ..... mos. ..... ds.

(Signed) H. F. Neal M. D.

12-21 1920 (Address) Meridian Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Meridian Cemetery	Dec 21 1920
20. UNDERTAKER	ADDRESS
W. S. Mateer	Meridian Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Stewart.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32765

Registered No. 6

1. PLACE OF DEATH

County of Ada

City of Boise.

Registration District No. 2

Primary Registration District No. 1094

(No. St Lukes Hospital St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Seth Morgan

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
M.	White.	Widowed

6. DATE OF BIRTH: Sep 11 (Month) (Day) 1851 (Year)

7. AGE: 69 Yrs. 3 Mos. 19 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missourri

10. NAME OF FATHER: Morgan

11. BIRTHPLACE OF FATHER (State or Country): Unknown.

12. MAIDEN NAME OF MOTHER: Unknown

13. BIRTHPLACE OF MOTHER (State or Country): Unknown.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nate Morgan

(Address)

15. Filed Jan 5 1921 R H Pate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 30 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 20 1920 to ~~Jan~~ Dec 30 1920 that I last saw him alive on Dec 30 1920, and that death occurred on the date stated above, at 5. P. M.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(Duration) 3 Yrs. mos. ds.

Contributory (Secondary) Chronic Myocarditis

(Duration) yrs. 2 mos. ds.

(Signed) T. N. Braxton M. D.

Dec 30 1920 (Address) Boise, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Morris Hill Cem — DATE OF BURIAL: Jan 1 1921

20. UNDERTAKER: Summers & Hobbs — ADDRESS: Boise Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32798

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Bannock — Registration District No. 28

City of Lafayette — Primary Registration District No. 2141

(No. South of Lafayette Ranch St.) — File No. 37

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Ann Marley — Registered No. 3482

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Widow

6. DATE OF BIRTH: May 13 (Month) (Day) 1844 (Year)

7. AGE: 76 Yrs. 7 Mos. 18 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Linnell

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Mary Painter

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) N. S. Henson
(Address) Lafayette

15. Filed 1/1 1921 — J. R. Young, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 31 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/31/20 to 12/31/20 that I last saw h.. alive on 12/31/20, and that death occurred on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:
Myocarditis

(Duration) 3 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Senility

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. R. Young M. D.
1/1 1921 (Address) Pocatello

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Franklin Idaho	Jan 4 1921

20. UNDERTAKER	ADDRESS
Schumacher & Hall	Pocatello

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2132
Primary Registration District No. 53
File No. 32804
Registered No.

1. PLACE OF DEATH
County of Bear Lake
City of Bloomington
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Fred Wilks
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH
Dec (Month) 12 (Day) 1843 (Year)

7. AGE
77 Yrs. Mos. 18 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Gardener
(b) General nature of industry, business or establishment in which employed (or employer) ~~Lindsel Essex England~~

9. BIRTHPLACE (State or Country) Lindsel Essex England

10. NAME OF FATHER John Wilks

11. BIRTHPLACE OF FATHER (State or Country) Lindsel Essex England

12. MAIDEN NAME OF MOTHER Charlotte Turner

13. BIRTHPLACE OF MOTHER (State or Country) Lindsel Essex England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John H Wilks
(Address) Paris

15.
Filed 1-10-21 D Sutton Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 29. 1920 to Dec 30 1920
that I last saw h~~im~~ alive on Dec 29 1920.
and that death occurred on the date stated above, at 10 A.M.
The CAUSE OF DEATH* was as follows:
Cardiac Asthma
(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) D Sutton M. D.
Dec 30-20 (Address) Paris Idaho.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Bloomington	Jan 2 1921

20. UNDERTAKER	ADDRESS
Bishop Hess.	Bloomington

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

32805

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 116
Primary Registration District No. 215
(No. ....., ... St.)

File No. 3
Registered No. 43

1. PLACE OF DEATH.
County of Bingham
City of Aberdeen
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary Friesen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): married

6. DATE OF BIRTH.
..... (Month) 1 (Day) 872 (Year)

7. AGE: 48 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Russia

10. NAME OF FATHER: Jacob Frank Enns

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: .....

13. BIRTHPLACE OF MOTHER (State or Country): Russia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) P. P. Friesen
(Address) .....

15. Filed Dec 7 20 191 ..... Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Aug (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug 24 1920, to Aug 24 1920, that I last saw h[illegible] alive on Aug 24 1920, and that death occured on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

(Duration) 2 Yrs. 6 mos. ..... ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) M. Enns, M. D.
12/7 1920 (Address) Aberdeen Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Mennonite Cemetery — DATE OF BURIAL: Sept 2 1920

20. UNDERTAKER: Friends — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 57

Primary Registration District No. 2022

File No. 32806

County of Blaine

City of Hailey, (No. ....., ... St.)

Registered No. /

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wm A. Slayton.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married.

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 55 yrs. about mos. ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Capitalist
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Vermont.

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): —

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): —

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank Fillon
(Address) Hailey, Ida.

15. Filed Dec 1 21 1920 Robt Hemingway Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Oct. (Month) 15 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from ~~~~ 191..., to ~~~~ 191...,
that I last saw h~~ alive on ~~~~ 191...,
and that death occurred on the date stated above, at ~~ M.
The CAUSE OF DEATH* was as follows: Found dead,
Probably valvular
heart-lesion.

..... (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Robt Hemingway Coroner M. D.

10-16 1920 (Address) Hailey Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Oakland, Calif. DATE OF BURIAL: ..... 191...

20. UNDERTAKER: P D Harris ADDRESS: Hailey Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32812

Registered No.

1. PLACE OF DEATH

County of Bonner

City of Sandpoint (No. City Hospital St.)

Registration District No. 79

Primary Registration District No. 2185

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martha Elizabeth Bower

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov. (Month) 17 (Day) 1875 (Year)

7. AGE: 45 Yrs. 1 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo.

10. NAME OF FATHER: Joab Smith

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER: x x Snoot

13. BIRTHPLACE OF MOTHER (State or Country): Va.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sidney J. Miller

(Address) Uniontown, Wash.

15. Filed Jan 24 1921 Hoyt E. Wendle Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-11 1920 to 12-21 1920 that I last saw her alive on 12-20 1920, and that death occurred on the date stated above, at 1:25 P.M.

The CAUSE OF DEATH* was as follows:

malignant neoplasm, abdominal.

(Duration) 1 Yrs. mos. ds.

Contributory (Secondary) nephritis

(Duration) (?) yrs. mos. ds.

(Signed) M. P. Wallenstein M. D.

Dec 19 20. (Address) Sandpoint, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR ~~REMOVAL~~: Sandpoint, Ida. DATE OF BURIAL: Dec 22 1920

20. UNDERTAKER: B. H. Pugh. By Mrs. B. H. P. ADDRESS: Sandpoint

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32813
Registered No.

1. PLACE OF DEATH
County of Boaer
City of Sandpoint
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 78
Primary Registration District No. 2155
(No. ... St.)

2. FULL NAME Hans Angirsen Hanson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: 50 November (Month) 20 (Day) 1870 (Year)

7. AGE: Yrs. 50 Mos. 0 ds. 18
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sollestad Denmark

10. NAME OF FATHER: Lars Nielsen

11. BIRTHPLACE OF FATHER (State or Country): Sollestad Denmark

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): mrs H C Nielsen
(Address): Careywood Idaho

15. Filed Jan 24 1921 Floyd Ellsworth Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8th (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from August 1 1920 to Dec. 8 1920
that I last saw him alive on Nov. 1 1920,
and that death occurred on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:
Interstitial nephritis

(Duration) Yrs. 3 mos. 8 ds.
Contributory (Secondary) General oedema - Cardiac failure (Duration) yrs. 1 mos. ds.

(Signed) Ralph Hanson M. D.
12/9 1920 (Address) Spokane Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. DURATION OF RESIDENCE. (For Hospitals, Institutions, Transients or Recent Residents.)
Where was disease contracted if not at place of death
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Weatherwood Ida | DATE OF BURIAL: Dec 10 1920

20. UNDERTAKER: Q. W. Estanc | ADDRESS: Rathdrum Idaho

Correction of name made by Floyd Ellsworth Local Registrar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-18.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32824

Registered No.

1. **PLACE OF DEATH**

County of Middle Butte

City of Moore

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 59

Primary Registration District No. 2129

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** Elizabeth Jeppeson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
F	White	single (Write the word.)

6. **DATE OF BIRTH** April 29 (Month) (Day) 1888 (Year)

7. **AGE** 32 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) Nantua, Utah

10. **NAME OF FATHER** H.N. Jeppeson

11. **BIRTHPLACE OF FATHER** (State or Country) Denmark

12. **MAIDEN NAME OF MOTHER** Maria Jeppeson

13. **BIRTHPLACE OF MOTHER** (State or Country) Denmark

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) C.N. Jeppeson

(Address) Moore, Idaho

15. Filed 12/12 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** December 12 (Month) (Day) 1920 (Year)

17. **I HEREBY CERTIFY, That I attended deceased from** 12/12 1920 to 12/12 1920 that I last saw h.. alive on 12/12 1920, and that death occurred on the date stated above, at 6.25 M.

The CAUSE OF DEATH* was as follows: A

Epilepsy

(Duration) 20 Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

12/12 1920 (Address) Arco, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL** Moore, Idaho — **DATE OF BURIAL** 12/13 1920

20. **UNDERTAKER** C.N. Jeppeson — **ADDRESS** moore, ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

EYER-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32826
Registered No.

1. PLACE OF DEATH
County of Butte
City of Moore
(No. , St.)
Registration District No. 59
Primary Registration District No. 2/29
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mrs. Joan McNeil Beverland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write word): Widowed

6. DATE OF BIRTH: Jan (Month) 11 (Day) 1838 (Year)

7. AGE: 82 Yrs. 10 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Paisley, Scotland

10. NAME OF FATHER: McNeil

11. BIRTHPLACE OF FATHER (State or Country): Scotland

12. MAIDEN NAME OF MOTHER: Marian Doby

13. BIRTHPLACE OF MOTHER (State or Country): Scotland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. James Kirn
(Address) Moore, Ida

15. Filed Dec 10 1920
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 7 (Day) 1920 (Year)

I HEREBY CERTIFY, That I attended deceased from Dec. 6 — 1920 to ——— 19....
that I last saw her alive on Dec. 6 — 1920
and that death occurred on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. M. Cannon M. D.
12/10 1920 (Address) Arco, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Moore, Ida
DATE OF BURIAL: 12-9-1920

20. UNDERTAKER: Allen J. Beverland
ADDRESS: Moore, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32865

Registered No.

Registration District No.

Primary Registration District No. 6

(No. , St.)

1. PLACE OF DEATH

County of Gem

City of Sweet R F D

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME June Elizabeth Bowman

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Girl

4. COLOR OR RACE: White American

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: June (Month) 21 (Day) 1917 (Year)

7. AGE: 3 Yrs. 6 Mos. 28 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: E. R. Bowman.

11. BIRTHPLACE OF FATHER (State or Country): Idaho

12. MAIDEN NAME OF MOTHER: Louise Phillips

13. BIRTHPLACE OF MOTHER (State or Country): Arkansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant): E. R. Bowman

(Address): Sweet Ida.

15. Filed 2/1 1921 J. H. Reynolds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1920 to Dec 28 1920 that I last saw her alive on Dec 27 1921, and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Dyspepsia & fever

(Duration) Yrs. mos. 21 ds.

Contributory (Secondary) Meningitis

(Duration) yrs. mos. 14 ds.

(Signed) A. G. Byrd M. D.

Dec 29 1920 (Address) Emmett Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Sweet Idaho

DATE OF BURIAL: Dec 31 1920

20. UNDERTAKER

ADDRESS

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 103
Primary Registration District No. 1007
(No. ..... , ... St.)

File No. 32875
Registered No. .....

1. PLACE OF DEATH.
County of Idaho
City of Grangeville
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mary E Kurz

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Widowed

6. DATE OF BIRTH. March (Month) 23d (Day) 1840 (Year)

7. AGE: 80 Yrs. 8 Mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Jefferson Co Virginia

10. NAME OF FATHER: Frederick Muhlenberg

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Jenett Rice

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Grafton F. Johnson
(Address) Grangeville Idaho

15. Filed Feb 1 1921 — G S Stockton, Local Registrar

SYMS - YORK CO., PTRS. & SONS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 15 1920 to Dec 15 1920, that I last saw her alive on Dec 15 1920 and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) ..... Yrs. ..... mos. 2 hours ds.

Contributory (Secondary): Arteriosclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) G S Stockton M. D.

12/16 1920 (Address) Grangeville Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Prairie view — DATE OF BURIAL: Dec 16th 1920

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32877
Registered No. 867

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. 801 Foster ave St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert E McFarland
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Nov (Month) 21 (Day) 1857 (Year)

7. AGE: 63 Yrs. 1 Mos. 0 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lawyer.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mo

10. NAME OF FATHER: William B. McFarland

11. BIRTHPLACE OF FATHER (State or Country): Penn

12. MAIDEN NAME OF MOTHER: Ruth E. Early

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. B. McFarland
(Address) Coeur d'Alene Ida

15. Filed Jan 4 1921 D D Dremna
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 18 1920 to Dec 21 1920 that I last saw h[illegible] alive on Dec 21 1920 and that death occurred on the date stated above, at 5.15 A.M.
The CAUSE OF DEATH* was as follows:
Pleuro-pneumonia
(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. 8 ds.
(Signed) D D Dremna M. D.
12/21 1920 (Address) Coeur d Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. 36 mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: St Thomas Cemetery | DATE OF BURIAL: 12-23 1920

20. UNDERTAKER: R B Mooney | ADDRESS: Coeur d'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

Registration District No. 30

Primary Registration District No. 1051

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32878

Registered No. 866

1. **PLACE OF DEATH**

County of Kootenai

City of Coeur d'Alene (No. 60, Coeur d'Alene St.)

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Richard B. Dickerson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. **DATE OF BIRTH** Feb (Month) ..... (Day) 1856 (Year)

7. **AGE** 64 Yrs. 10 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country) Ky

10. **NAME OF FATHER**

11. **BIRTHPLACE OF FATHER** (State or Country)

12. **MAIDEN NAME OF MOTHER**

13. **BIRTHPLACE OF MOTHER** (State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mrs R. B Dickerson

(Address) Coeur d'Alene, Ida

15. Filed Jan 7 1921 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** December (Month) 19 (Day) 1920 (Year)

17. **I HEREBY CERTIFY**, That I attended deceased from Dec. 17 1920, to Dec. 19 1920 that I last saw h.im alive on Dec. 19 1920 and that death occurred on the date stated above, at 8 a M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) ..... Yrs. ..... mos. 4 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Allwood M. D.

Dec 19 1920 (Address) Coeur d'Alene. Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State 8 yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	12-21 1920

20. **UNDERTAKER** I B Mooney ADDRESS Coeur d'Alene

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-05 R. 1-10.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32879
Registered No. 863

1. PLACE OF DEATH
County of Kootenai
City of
(No. Hutton Ave. St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs S. Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: Unknown (Month) (Day) 1 (Year)

7. AGE: about 48 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): [illegible]

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lawrence Larsen
(Address) Coeur d'Alene, Ida.

15.
Filed Jan 4 1921 D D Dressman Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 12 noon M.

The CAUSE OF DEATH* was as follows:
Fell 100 feet while Painting
Smoke Stack. Body Crushed
(accidental)
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. M. Elder M. D.
12/22 1920 (Address) Coeur d'Alene

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. 3 days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: 12/22, 1920

20. UNDERTAKER: R B Mooney
ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32880
Registered No. 864

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene Mica
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Jas. A. Canfield
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M.	W.	widower

6. DATE OF BIRTH: March (Month) 1 (Day) 1846 (Year)

7. AGE: 74 Yrs. 8 Mos. 11 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): N. Y.

10. NAME OF FATHER: Silas Canfield

11. BIRTHPLACE OF FATHER (State or Country): N. Y.

12. MAIDEN NAME OF MOTHER: — Austin.

13. BIRTHPLACE OF MOTHER (State or Country): N. Y.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R B Canfield
(Address) 502-E 23rd. Spokane. Wash.

15. Filed Jan 4 1921 D D Drenna Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19....., that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Found dead in Bed,
Some form of Heat disease
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) D D Drennan M. D.
12/14 1920 (Address) Cda

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cem. CD'Alene | DATE OF BURIAL: 12-14 1920

20. UNDERTAKER: C Carrecky | ADDRESS: CD'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1057
File No. 32881
Registered No. 863

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. Hayden Lake St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Francis Frazee
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Unknown (Month) (Day) 1868 (Year)

7. AGE: 52 Yrs. Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Unknown

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Ed. Frazee
(Address) Coeur d' Alene Ida.

15. Filed Jan 4, 1921 D Drenna
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 8 1920, to Dec 3 1920, that I last saw h— alive on Nov 27 1920, and that death occurred on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:
Endocarditis.

(Duration) 8 Yrs. — mos. — ds.
Contributory (Secondary) Influenza about 1 yr ago.
(Duration) 1 yrs. mos. — ds.

(Signed) F. H. Hoadley M. D.
12/4 1920 (Address) Coeur d Alene Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State 1 yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery
DATE OF BURIAL: Dec 5 1920

20. UNDERTAKER: R B Mooney
ADDRESS: Coeur d'Alene

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1651
File No. 32892
Registered No. 873

1. PLACE OF DEATH

County of Kootenai
City of Rathdrum
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charls Charlton

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 18 (Day) 1849 (Year)

7. AGE: 80 Yrs. 6 Mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Engfand

10. NAME OF FATHER: James Charlton

11. BIRTHPLACE OF FATHER (State or Country): Engfand

12. MAIDEN NAME OF MOTHER: Mary A. Lovel

13. BIRTHPLACE OF MOTHER (State or Country): Engfand

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Lydia E. Flood
(Address) Post Pont Wn R 1

15. Filed Feb 4 1921 D D Dreman
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 11. 1920, to Dec 27. 1920 that I last saw h[illegible] alive on Dec 26. 1920, and that death occurred on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:
Arterio - Sclerosis

(Duration) 10 Yrs. ..... mos. ..... ds.

Contributory (Secondary) Old age

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank [illegible] M. D.
12/28 1920 (Address) Rathdrum Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rathdrum Ida — DATE OF BURIAL: Dec 29 1920

20. UNDERTAKER: A. W. Storm — ADDRESS: Rathdrum Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 30
Primary Registration District No. 1051
File No. 32894
Registered No. 377

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene (No. Stanley St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Edward Stanley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: May (Month) 7 (Day) 1853 (Year)

7. AGE: 67 Yrs. 7 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Rancher
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ireland

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country):

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Miss Florence Stanley
(Address) Coeur d'Alene Idaho

15. Filed Feb. 4 1921 — D D Drennan, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 21st 1920 to Dec 23 1920
that I last saw h[im] alive on Dec 21 1920,
and that death occurred on the date stated above, at 3 A. M.
The CAUSE OF DEATH* was as follows:

Asthma Pectoris

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. O'Brien M. D.
Dec 24 1920 (Address) Coeur d'Alene Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Forest Cemetery — DATE OF BURIAL: 12-26-1920

20. UNDERTAKER: P B Mooney — ADDRESS: Coeur d'Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-A—25 M. 1-19.

32896

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
File No. 3
Registered No. 73

1. PLACE OF DEATH
County of Kootenai
City of Harrison
(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Not Named

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Dec 3 (Month) (Day) 1920 (Year)

7. AGE: 10 hours (Yrs. Mos. ds.)
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Lakeview Hospital

10. NAME OF FATHER: Helmer Johnson

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Edith Crabtree

13. BIRTHPLACE OF MOTHER (State or Country): Neb

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Silliam Bradgeman
(Address) .....

15. Filed Jan 1 1921
J. M. Tenney
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 3 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, that I attended deceased from Dec 3 1920 to ..... 19....
that I last saw her alive on Dec 3 1920
and that death occurred on the date stated above, at 9 P.M.,
The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) 10 hours Yrs. mos. ds.
Contributory (Secondary) Not known
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) C. E. Worthington M. D.
19..... (Address) Harrison Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? ✓
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19.....

20. UNDERTAKER | ADDRESS

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

32897

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 126
Primary Registration District No. 2204
File No. 3
Registered No. 96

1. PLACE OF DEATH
County of Kootenai
City of Harrison
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Premature Born
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): ✓

6. DATE OF BIRTH: Dec (Month) 11 (Day) 1920 (Year)

7. AGE: approximately 4 hrs (.....Yrs. .....Mos. .....ds.)
IF LESS than 1 day how many 4 hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: ✓
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Kootenai Co Ida

10. NAME OF FATHER: Albert Newton

11. BIRTHPLACE OF FATHER (State or Country): Harrison Ida

12. MAIDEN NAME OF MOTHER: Ruth Sprague

13. BIRTHPLACE OF MOTHER (State or Country): Wis

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed Jan 7 1921
J. H. Tanney
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from at birth to birth 19.....
that I last saw her alive on Dec 11 1920
and that death occurred on the date stated above, at 1 P M.
The CAUSE OF DEATH* was as follows:
Premature birth
Sev months
(Duration) .....Yrs. .....mos. .....ds.
Contributory (Secondary) .....
(Duration) .....yrs. .....mos. .....ds.
(Signed) C. E. Worthington M. D.
19..... (Address) Harrison Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19.....

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

32898

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Kootenai
City of Rose Lake

Registration District No. 126
Primary Registration District No. 2204
(No. ..... St.)

File No. 9
Registered No. 75

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Bertha Clara Dowell.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	white	married

6. DATE OF BIRTH. June (Month) 28 (Day) 1864 (Year)

7. AGE 56 Yrs. 5 Mos. 8 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Housewife
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Illinois

10. NAME OF FATHER M. A. Eaton

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Sophia Weld

13. BIRTHPLACE OF MOTHER (State or Country) New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. G. Dowell
(Address) Rose Lake, Idaho

15. Filed Jan 1 1921 — J. W. Thomas, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 6 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 5 1920, to Dec 6 1920, that I last saw h[illegible] alive on Dec 5 1920, and that death occured on the date stated above, at 2:30 P. M.

The CAUSE OF DEATH* was as follows:
Chronic parenchymatous nephritis

(Duration) ..... Yrs. 6 mos. ..... ds.
Contributory (Secondary) Chronic Myocarditis
(Duration 2 yrs. ..... mos. ..... ds.
(Signed) L. J. Stauffer M. D.
Dec 7 1920 (Address) Rose Lake, Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL St Maries, Idaho — DATE OF BURIAL Dec 8 1920

20. UNDERTAKER M. C. Thornhill — ADDRESS Kellogg Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

BYRD - YORK CO., PTRS. & BDRS. 24658

[redacted] CERTIFICATE OF [redacted] DEATH.

[redacted] of [redacted]
[redacted] OF [redacted]
Bureau of Vital [redacted]

1. PLACE OF DEATH

Registration District No. .....
Primary Registration District No. .....
File No. 32901
Registered No. .....

County of Latah
City of Juliaetta (No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Mrs. John Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: femal
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married.

6. DATE OF BIRTH. July (Month) 18 (Day) 1854 (Year)

7. AGE: 66 Yrs. 4 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa. Clark County

10. NAME OF FATHER: Willis Ball

11. BIRTHPLACE OF FATHER (State or Country): Illonis

12. MAIDEN NAME OF MOTHER: Emma Ball Axie

13. BIRTHPLACE OF MOTHER (State or Country): Iowa. Clark County

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John Jackson
(Address) Juliaetta Ida.

15.
Filed 12-10 1920
R F Pepple
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 10th 1920, to Dec 8th 1920, that I last saw her alive on Dec 1st 1920, and that death occured on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:

Acute Brights Disease

(Duration) 1 Yrs. 6 mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. A. Cartwell M. D.
Dec 9 1920 (Address) Kendrick Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Juliaetta Cem. | DATE OF BURIAL: 12-10 1920

20. UNDERTAKER: [signature] | ADDRESS: Juliaetta Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

BYMS - YORK CO., PTRS. & BOOS. 24858

Form V. S. No. 5. 10M. 6-20-11.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 32913
Registered No.

1. PLACE OF DEATH.
County of Latah
City of
(No. , St.)
Registration District No. 93
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp give its NAME instead of street and number.

2. FULL NAME Infant of Wm Wright

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single
6. DATE OF BIRTH: Dec 21 (Month) 21 (Day) 1920 (Year)
7. AGE: yrs. mos. ds. IF LESS than 1 day how many 2 hrs. or min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work
(b) General nature of industry business or establishment in which employed (or employer)
9. BIRTHPLACE (State or Country): Latah
10. NAME OF FATHER: Wm Wright
11. BIRTHPLACE OF FATHER (State or Country): Idaho
12. MAIDEN NAME OF MOTHER: Alice Walmot
13. BIRTHPLACE OF MOTHER (State or Country): Wisconsin
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Wm J Baker M.D.
(Address) Southwick
15.
Filed 1-25 1921 Daniel Lyle Local Registrar
Peck, Ida.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 21 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Birth to Dec 1920, to Dec 21 1920, that I last saw him alive on Dec 21 1920, and that death occurred on the date stated above, at 2 P.M.
The CAUSE OF DEATH* was as follows:
Prematurely Born
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Wm J Baker M. D.
Dec 21 1920 (Address) Southwick

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, stats (1) MEANS OF INJURY; and 2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191
20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & RULERS, BOISE 18672

FORM V. S. No. 5-25 M. 1-19.

Copy

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

32931

1. PLACE OF DEATH

Registration District No. 30

Primary Registration District No. 1057

County of Kootenai

City of Spokane Bridge (No. ....., ... St.)

File No. .....

Registered No. 868.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Heram Hearing.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married.

6. DATE OF BIRTH: Jan. (Month) 25 (Day) 1854 (Year)

7. AGE: 61 Yrs. 8 Mos. 16 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer.

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Hearing

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Mary Moore.

13. BIRTHPLACE OF MOTHER (State or Country): Pa.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Emma Hearing

(Address) Spokane Bridge, Idaho

15. Filed Jan. 4 1921 D D Dreman, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 13. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1, 1920, to Nov 13 1920 that I last saw him alive on Nov 12 1920 and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:

Heart failure Acute dilatation due to myocardial degeneration

(Duration) ..... Yrs. ..... mos. 3 ds.

Contributory (Secondary) Mitral insufficiency.

(Duration) ? yrs. 0 mos. — ds.

(Signed) Ralph Hanson. M. D.

Nov 14 1920 (Address) 521 Paulsen Bldg Spokane Wash

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pleasant View — DATE OF BURIAL: Nov. 15 1920

20. UNDERTAKER: Buchanan Co. — ADDRESS: Spokane

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32932

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. [redacted]
Registered No. 869

1. PLACE OF DEATH
County of Kootenai
City of Coeur d'Alene
(No. 513 Third St, St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 30
Primary Registration District No. 1051

2. FULL NAME Izora Thomas

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female.	White	Married.

6. DATE OF BIRTH: April (Month) 4 (Day) 1884 (Year)

7. AGE: 36 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House Wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: John Laverance

11. BIRTHPLACE OF FATHER (State or Country): Georgia

12. MAIDEN NAME OF MOTHER: Jennie Hustin

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David Thomas
(Address) Coeur d Alene Idaho

15. Filed Jan 4, 1920 D D Drennan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/17 1920 to 12/24 1920 that I last saw her alive on 12/24 1920, and that death occurred on the date stated above, at 8 P M.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage,
(Duration) 1 Yrs. — mos. 10 ds.
Contributory (Secondary) Sclerosis Liver Duct obstruction
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. G. Cartwright M. D.
1/22 1920 (Address) Valley Hack.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Forest Cemetery	Dec. 27 1920
20. UNDERTAKER	**ADDRESS**
C Cassedy	Coeur d Alene

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

32934

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. .....
Primary Registration District No. 21
File No. [redacted]
Registered No. .....

1. PLACE OF DEATH
County of Gooding
City of Hagerman
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles F Jones

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Nov (Month) 3 (Day) 1885 (Year)

7. AGE: 34 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer & sheep shearer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Neb

10. NAME OF FATHER: Frank L. Jones

11. BIRTHPLACE OF FATHER (State or Country): Neb. I think

12. MAIDEN NAME OF MOTHER: Flora A Bader

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Chas. F. Jones
(Address) .....

15. Filed Sept 24 1920 — R H Greene, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h~~e alive on~~ saw him alive
and that death occurred on the date stated above, at 11 48 M.
The CAUSE OF DEATH* was as follows:
Suicide

..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) R H Greene M. D.
Sept 24 1920 (Address) Hagerman

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR ~~REMOVAL~~: Hagerman Cemetery — DATE OF BURIAL: Sept 26 1920

20. UNDERTAKER: A E Thompson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

R. H. Greene Hagerman

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 10 1920

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 32988

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Adams

City of Council

Registration District No. 71

Primary Registration District No. .....

(No. ....., ... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elizabeth Jane Heathco

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. April (Month) 24 (Day) 1841 (Year)

7. AGE: 79 Yrs. 10 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wright Co. Mo.

10. NAME OF FATHER: Johnson Adams

11. BIRTHPLACE OF FATHER (State or Country): ~~Kansas~~ Kentucky

12. MAIDEN NAME OF MOTHER: Violet Gilstraft

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Jona Sanders
(Address) Council Idaho

15. Filed April 5 1920 W. M. Brown Local Registrar

STAR - YORK CO., PTRS. & STNRS. 24853

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
3 (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191 ..... to ..... 191 .....,
that I last saw her alive on ..... 191 .....,
and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows: Found dead in bed shortly after complaining of pain in Left Lung.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Brown M. D.

..... 19..... (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F.

DATE OF BURIAL: April 1 1920

20. UNDERTAKER: Keeney

ADDRESS

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

MAR 10 19

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 71

Primary Registration District No.

File No. 32980

Registered No.

1. PLACE OF DEATH

County of Adams

City of Council

(No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ira Brown

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White Caucasian

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widowed (Write the word.)

6. DATE OF BIRTH: January (Month) 16, (Day) 1842 (Year)

7. AGE: 78 Yrs. 8 Mos. 19 ds.

IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. W. E. Irwin

(Address) Portland, Oregon

15. Filed Oct 5 1920 W. M. Brown Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 2 1920, to Oct 4 1920, that I last saw h.. alive on Oct 4 1920, and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Uremic Poisoning

..... (Duration) ~ Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. M. Brown M. D.

Oct 5 1920 (Address) Council

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: I.O.O.F. DATE OF BURIAL: Oct 5 1920

20. UNDERTAKER: Feeney ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

MAR 19 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. Council 11

Primary Registration District No. Council

File No. 32000

County of Adams

City of Council (No. ....., ... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Calvin W. Johnson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 20 (Day) 1850 (Year)

7. AGE: 69 Yrs. 11 Mos. 20 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Fireman Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Wayne [redacted] Ohio

10. NAME OF FATHER: Marion Edmond Johnston

11. BIRTHPLACE OF FATHER (State or Country): Dayton Ohio

12. MAIDEN NAME OF MOTHER: Martha Jane Ewing

13. BIRTHPLACE OF MOTHER (State or Country): Don't Know

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Morris Johnston Brother
(Address) Council Idaho

15. Filed Mar 12 1921 — W. W. Brown, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 9 1920, to — 191..., that I last saw him alive on Nov 9 1920, and that death occured on the date stated above, at 5 1/2 A. M.

The CAUSE OF DEATH* was as follows: Bright's Disease

(Duration) Not known Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) W. W. Brown M. D.

19..... (Address) Council

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Normal Creek	Nov 12 1920
20. UNDERTAKER	ADDRESS

EVANS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 7
Primary Registration District No. 2006
File No. 33068
Registered No.

1. PLACE OF DEATH

County of Ada
City of Kuna
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Cora Escue

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Fem	white	Single (Write the word.)

6. DATE OF BIRTH: Oct (Month) 16 (Day) 1894 (Year)

7. AGE: 26 Yrs. Mos. ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ida.

10. NAME OF FATHER: W. M. Escue

11. BIRTHPLACE OF FATHER (State or Country): Ida

12. MAIDEN NAME OF MOTHER: Josephine Walker

13. BIRTHPLACE OF MOTHER (State or Country): Ida

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs L M Escue
(Address) Kuna Ida

15. Filed Feb 13 1921 Pearle Dodds Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 30 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Aug-18 1920, to Dec-30 1920, that I last saw her alive on Dec 31 1920, and that death occurred on the date stated above, at 9:20 P.M.

The CAUSE OF DEATH* was as follows:

10 Flu

(Duration) Yrs. mos. ds.

Contributory (Secondary) Pulmonary Abscess & Pulmonary Hemorrhage

(Duration) — yrs. 10 mos. — ds.

(Signed) A J Coleman M. D.

12-30 1920 (Address) Kuna Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Gowville Ida — DATE OF BURIAL: 1 19

20. UNDERTAKER: Enoch Robinson — ADDRESS: Nampa Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 2119
Primary Registration District No. 27
File No. 33088
Registered No.

1. PLACE OF DEATH
County of Franklin
City of Trink Creek (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James M. Keller
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.
4. COLOR OR RACE: W.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: June (Month) 9 (Day) 1865 (Year)

7. AGE: 55 Yrs. 6 Mos. 22 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah U.S.A.

10. NAME OF FATHER: James M Keller

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: Karen Margaret Valentine

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Laverne Knight
(Address) Trink Creek

15. Filed Jan 2 1921
D. A. Rutter
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19.. to ..... 19..
that I last saw him Did not see him alive on ..... 19....,
and that death occurred on the date stated above, at 4:15 P.M.
The CAUSE OF DEATH* was as follows:
Carcinoma of the Stomach
(Operated at L D S Hospital Salt Lake City)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Allen R Cutler M. D.
1/2 1921 (Address) Preston Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Trink Creek Ida. DATE OF BURIAL: Jan. 3 1921

20. UNDERTAKER: W. A. Skidmore ADDRESS: Preston Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-12 M. 6-15-17.

CERTIFICATE OF DEATH

Registration District No. 41 MAR 10 1921

Primary Registration District No. 216

(No. ....., ... St.)

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33131
Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Lemhi
City of Leadore
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Naomi Rees

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: Nov 11th (Month) (Day) 1855 (Year)

7. AGE: 62 Yrs. 1 Mos. 16 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: William Walker

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Kissiah Taylor

13. BIRTHPLACE OF MOTHER (State or Country): Illinois

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Eva R Matheweon
(Address) Salmon Idaho

15. Filed 2/10 1921 W. D. Greene Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December 27th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 10 1920 to Dec 27th 1920 that I last saw h.er alive on Dec 27 1920 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:
Valvular Heart disease
.....
.....
.....(Duration) ..... Yrs..... mos. ..... ds.

Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.

(Signed) J. W. Kellen M. D.
Dec 29 1920 (Address) 4695 Hollywood Blvd Calif

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ....yrs....mos....days. In the State....yrs....mos....days

Where was disease contracted if not at place of death? 5431½ Hollywood Blvd

Former or usual residence Calif.

19. PLACE OF BURIAL OR REMOVAL: Junction Cemetery
DATE OF BURIAL: 1-4 1921

20. UNDERTAKER: Jos C Tobler
ADDRESS: Salmon Ida

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No.
Primary Registration District No.
(No. , St.)

File No. 33135
Registered No.

1. PLACE OF DEATH

County of Lewis
City of Winchester

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Kathrine May Stearns

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Female	White	Single

6. DATE OF BIRTH: July (Month) 14 (Day) 1920 (Year)

7. AGE: Yrs. 2 Mos. 4 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Winchester Idaho

10. NAME OF FATHER: Harry A. Stearns

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Florence V. Dorsney

13. BIRTHPLACE OF MOTHER (State or Country): New Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry A. Stearns
(Address) Winchester Idaho

15. Filed 19 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept (Month) 18. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 12 1920 to Sept 17 1920 that I last saw her alive on Sept 17 1920 and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Gastro-Enteritis

(Duration) Yrs. mos. 8 ds.

Contributory (Secondary) Bottle Fed

(Duration) yrs. mos. ds.

(Signed) J. O. McLaughlin M. D.

Sept 18 1920 (Address) Winchester, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH

MAR 10 1921

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 48
Primary Registration District No. 2127
(No. ..... St.)

File No. 33120
Registered No. 5

1. **PLACE OF DEATH**

County of Lewis
City of Winchester

If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Mrs. Hulda Lindgren

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Female

4. **COLOR OR RACE**: White

5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Married

6. **DATE OF BIRTH**: ..... (Month) ..... (Day) 1 (Year)

7. **AGE**: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. **BIRTHPLACE** (State or Country)

10. **NAME OF FATHER**

11. **BIRTHPLACE OF FATHER** (State or Country)

12. **MAIDEN NAME OF MOTHER**

13. **BIRTHPLACE OF MOTHER** (State or Country)

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) .....

(Address) .....

15. Filed ..... 19.....

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**

Feb. (Month) 11 (Day) 1920 (Year)

Had no medical attendant

17. **I HEREBY CERTIFY, That I attended deceased from**

..... 19..... to ..... 19.....

that I last saw h..... alive on ..... 19.....

and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Think is was Pneumonia

(Duration) ..... Yrs. ..... mos. 8 ds.

Contributory (Secondary) Influenza

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Laughlin M. D.

Feb. 11 19 20 (Address) Winchester Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients or Recent Residents.)**

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. **PLACE OF BURIAL OR REMOVAL**: Slo Cemetery — **DATE OF BURIAL** ..... 19.....

20. **UNDERTAKER** — **ADDRESS**

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

W. E. Stoddard Gifford-Idaho

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33140
Registered No. 6

Registration District No. 48
Primary Registration District No. 2127

1. **PLACE OF DEATH**
County of Lewis
City of Reubens
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. **FULL NAME** Abbie Rice Raymond
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. **SEX**: Female
4. **COLOR OR RACE**: White
5. **SINGLE, MARRIED, WIDOWED OR DIVORCED** (Write the word.): Widowed

6. **DATE OF BIRTH**: Dec (Month) 11 (Day) 1855 (Year)

7. **AGE**: 64 Yrs. 3 Mos. 0 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. **BIRTHPLACE** (State or Country): Iowa

10. **NAME OF FATHER**: W. W. Hunt

11. **BIRTHPLACE OF FATHER** (State or Country): United States

12. **MAIDEN NAME OF MOTHER**: Elmira Salter

13. **BIRTHPLACE OF MOTHER** (State or Country): Ohio

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Mrs. D. R. Russell
(Address) Reubens, Idaho

15. Filed Mar. 11 1920 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH**: March (Month) 11 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept-# 1919, to Mar-11- 1920 that I last saw h.er alive on Mar.-11- 1920 and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(Duration) 0 Yrs. 6 mos. 0 ds.
Contributory (Secondary): Pernicious Anaemia
(Duration) 2 yrs. 0 mos. 0 ds.

(Signed) Jos. McLaughlin M. D.
M. Alvord Stone - M. D.
3/11 1920 (Address) Reubens - Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE** (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. **PLACE OF BURIAL OR REMOVAL**: Independence - Iowa — **DATE OF BURIAL** 1920

20. **UNDERTAKER**: W. E. Stoddard — **ADDRESS**: Gifford - Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 3358
Registered No. 1

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Susan Helm
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: April 23 1860 (Month) (Day) (Year)

7. AGE: 60 Yrs. 8 Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Ellis Griffis

11. BIRTHPLACE OF FATHER (State or Country): Wales

12. MAIDEN NAME OF MOTHER: Mary Griffis

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) William Helm
(Address) Paul Idaho

15. Filed Feb 4 1921 E. T. Edmunds Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec 23 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 16 1920, to Dec 23 1920
that I last saw her alive on Dec. 18 1920.
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Chronic Endocarditis
(Duration) 4 Yrs. ..... mos. ..... ds.
Contributory (Secondary) Arterio-sclerosis
(Duration) 8 yrs. ..... mos. ..... ds.
(Signed) E. T. Edmunds M. D.
2-4 1921 (Address) Rupert Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery
DATE OF BURIAL: Dec 24 1920

20. UNDERTAKER: W. A. Goodman
ADDRESS: Rupert

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

MAR 1 0

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
(No. ....., ... St.)

File No. 3315
Registered No. 2

1. PLACE OF DEATH.
County of Minidoka
City of Rupert

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Moller.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: W.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)

6. DATE OF BIRTH. Dec. (Month) 20 (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. ..... ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... —
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Rupert Idaho.

10. NAME OF FATHER Rob Moller.

11. BIRTHPLACE OF FATHER (State or Country) Denmark.

12. MAIDEN NAME OF MOTHER Elinor Olson.

13. BIRTHPLACE OF MOTHER (State or Country) Denmark.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) V. R. Killen M D.
(Address) Rupert.

15. Filed Feb. 6 1921 E. H. Elmore Local Registrar

SYMS - YORK CO., PTRS. & BORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
Dec. (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on Dec 20 1920
and that death occured on the date stated above, at 12 P. M.
The CAUSE OF DEATH* was as follows:
~~(a)~~ Pulmonary Edema (a)
(b)
(c)
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) V. R. Killen M. D.
19..... (Address) Rupert Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 191...

20. UNDERTAKER | ADDRESS

FORM V. S. No. 5-12 M. 6-15-17.

MAR 10 1921

Cooper.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33161
Registered No. 4

1. PLACE OF DEATH
County of Minidoka.
City of Burley Heyburn
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 19
Primary Registration District No. 2015
(No. ....., ... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Bessie L. Matthews.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct. (Month) 16 (Day) 1890 (Year)

7. AGE: 30 Yrs. 2 Mos. 1 ds. IF LESS than 1 day how many .... hrs. or .... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas.

10. NAME OF FATHER: George Scarbrough

11. BIRTHPLACE OF FATHER (State or Country): Mo.

12. MAIDEN NAME OF MOTHER: Laura Edwards.

13. BIRTHPLACE OF MOTHER (State or Country): England.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jesse L. Matthews.
(Address) R. F. D. #1. Heyburn Ida.

15. Filed 12-18 1920. E. E. Elmore Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 1920 to Dec. 17 1920
that I last saw her alive on Dec. 17. 1920.
and that death occurred on the date stated above, at 12:45 P.M.

The CAUSE OF DEATH* was as follows:
Valvular Heart Disease
Chronic.
(Duration) 10 Yrs. 7 mos. ds.

Contributory (Secondary)
(Duration) Yrs. mos. ds.

(Signed) E. E. Cooper M. D.
12-18-1920 (Address) Burley Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Louisburgh Mo By way of Bolivar
DATE OF BURIAL ..... 191...

20. UNDERTAKER: L. B. Scaggy.
ADDRESS: Burley Ida.

FORM V. S. No. 5-25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 3162
Registered No. 5

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Raymond Shinn
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Widower

6. DATE OF BIRTH: May (Month) 30 (Day) 1857 (Year)

7. AGE: 69 Yrs. 6 Mos. 16 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Branchr
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: Emery Shinn

11. BIRTHPLACE OF FATHER (State or Country): Illinois

12. MAIDEN NAME OF MOTHER: Dont Know

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Arthur Shinn
(Address) Rupert R.R. 2

15. Filed 2-6 1921 E. O. Elmore Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 1 1920, to Dec. 15 1920
that I last saw him alive on Dec 15 1920
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Cardiac Asthenia
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) V. P. Kilbr M. D.
19..... (Address) Rupert

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery — DATE OF BURIAL: Dec 17 1920

20. UNDERTAKER: W. A. Goodman — ADDRESS: Rupert Idaho

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 33164
Registered No. 7

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rufus J Williams
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word.): Married

6. DATE OF BIRTH: April (Month) 8 (Day) 1850 (Year)

7. AGE: 70 Yrs. 8 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ohio

10. NAME OF FATHER: James K Willims

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Lydia Martin

13. BIRTHPLACE OF MOTHER (State or Country): Ohio

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) B M Thomason
(Address) Rupert Idaho

15. Filed Jan. 17 1921 E H Elmore, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1920, to Dec 18 1920, that I last saw h— alive on Dec 16 1920, and that death occurred on the date stated above, at 8 P. M.
The CAUSE OF DEATH* was as follows: Carcinoma of Stomach
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... Yrs. ..... mos. ..... ds.
(Signed) C E Spangler M. D.
1/15 1921 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rupert Cemetery
DATE OF BURIAL: Dec 19 1920

20. UNDERTAKER: W. G. Goodman
ADDRESS: Rupert Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

MAR 10 Gooding

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2015
File No. 33167
Registered No. 10

1. PLACE OF DEATH
County of Minidoka
City or [redacted]doka
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Owen Lewis Collins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Child

6. DATE OF BIRTH: Sept (Month) 18 (Day) 1905 (Year)

7. AGE: 15 Yrs. 2 Mos. 20 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Bert Collins

11. BIRTHPLACE OF FATHER (State or Country): Kent Kans

12. MAIDEN NAME OF MOTHER: Mildred Sears

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Pearl D. Sears
(Address) Minidoka

15. Filed Feb. 14 1921 Ella Eliason Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1920 to Dec 8 1920 that I last saw h[redacted] alive on Dec 7 1920 and that death occurred on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Heart Disease

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) [redacted] M. D.

1920 (Address) Rupert Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Albion Cemetery — DATE OF BURIAL: Dec 11 1920

20. UNDERTAKER: W. G. Goodrich — ADDRESS: Rupert Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33168

Registered No. 11

Registration District No. 19

Primary Registration District No. 2215

1. PLACE OF DEATH

County of Minidoka

City of Rupert (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Still born Shaver

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Child

6. DATE OF BIRTH: Dec (Month) 9 (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or 20 min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: Jay M Shaver

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Emma A Gipson

13. BIRTHPLACE OF MOTHER (State or Country): Nebraska

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Jay M Shaver
(Address) Rupert Idaho

15. Filed Feb 14 1921 Ed D Elmore, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 9 1920 to Dec 9 1920 that I last saw h~~e alive on~~ Dec 9 1920 and that death occurred on the date stated above, at 6 P. M.

The CAUSE OF DEATH was as follows:

Still born

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

..... 19..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Rupert Cemetery	Dec 10 1920
20. UNDERTAKER	ADDRESS
W. A. Goodman	Rupert Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 96
Primary Registration District No. 1009
(No. ....., ... St.)

File No. 3317
Registered No. 589

1. PLACE OF DEATH
County of Nez Perce
City of Lewiston

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virgil Manwaring

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 9 (Day) 1919 (Year)

7. AGE: 1 Yrs. 6 Mos. 6 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: L. F. Manwaring

11. BIRTHPLACE OF FATHER (State or Country): Ill.

12. MAIDEN NAME OF MOTHER: Julia Deardorff.

13. BIRTHPLACE OF MOTHER (State or Country): Oregon.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R. C. Manwaring
(Address) 1116 Idaho st

15. Filed Feb 8 1921 Susan E Bruce Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Jan (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan 15 1921 to Jan 15 1921 that I last saw h. l. alive on Jan 15 1921, and that death occurred on the date stated above, at 8-30 A.M.

The CAUSE OF DEATH* was as follows:
Pneumonia

(Duration) ..... Yrs. ..... mos. 7 ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) John B Alley M. D.
1921 (Address) Lewiston

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Lewiston, Idaho.
DATE OF BURIAL: Jan 19 21

20. UNDERTAKER: Vassar Undertaking Co.
ADDRESS: Lewiston

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

MAR 10 1921

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 130
Primary Registration District No. Homedale
File No. 33196
Registered No.

1. PLACE OF DEATH
County of Owyhee
City of Homedale
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Elsie Sample
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: single (Write the word.)

6. DATE OF BIRTH: May 1- (Month) (Day) 1920 (Year)

7. AGE: — Yrs. 7 Mos. 25 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: at Home.
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: W. E. Sample

11. BIRTHPLACE OF FATHER (State or Country): Iowa.

12. MAIDEN NAME OF MOTHER: Flora E. Green

13. BIRTHPLACE OF MOTHER (State or Country): Missouri

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. E. Sample
(Address) W. Homedale Ida

15. Filed Jan 1 1920 S. Hopper Local Registrar

STUB-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 26 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 14 1920 to Dec 26 1920 that I last saw her alive on ..... 19..., and that death occurred on the date stated above, at 8:30 A.M.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Duration) ..... Yrs. ..... mos. 12 ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Simeon Hopper M. D.
19..... (Address) Homedale Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Canyon Hill
DATE OF BURIAL: 12-27 1920

20. UNDERTAKER: C. V. Peetcham
ADDRESS: Caldwell, Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

MAR 10 1921

33204

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 123

Primary Registration District No. 7701

File No. 5

County of Shoshone

City of Kellogg (No. ..... St.)

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Olga Irene Wirta

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: Aug (Month) 13 (Day), 1914 (Year)

7. AGE: 5 yrs. 8 mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Aberdeen Wash

10. NAME OF FATHER: Everd Wirta

11. BIRTHPLACE OF FATHER (State or Country): Finland

12. MAIDEN NAME OF MOTHER: Olga Jacksonen

13. BIRTHPLACE OF MOTHER (State or Country): Finland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Olga Wirta

(Address) Kellogg

15.

Filed 1/11 1921 Jno S Lesher Local Registrar

MEDICAL CERTIFICATE OF DEATH.

Mc Cracken

16. DATE OF DEATH: May (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 4 1920 to May 9 1920, that I last saw her alive on May 9 1920, and that death occurred on the date stated above, at 8:55 P.M.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Alex McCracken M. D.

May 16 1920 (Address) Kellogg Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kellogg | DATE OF BURIAL: May 11 1920

20. UNDERTAKER: M. C. Thorhild | ADDRESS: Kellogg

SYMS - YORK CO., PTRS. & BDRS. 19760

MAR 10 1921

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 86
Primary Registration District No. 2112
File No. 33226
Registered No. 9

1. PLACE OF DEATH
County of Washington
City of Weiser
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dan Lookins
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 38 Yrs. — Mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Sheep Foreman
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: Thos Lookins

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Nancy Cooper

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John W Davis
(Address) Weiser Idaho

15. Filed Jan 29th 1921 — W. R. Hamilton, Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov. (Month) 22 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at ..... M.
The CAUSE OF DEATH* was as follows:
Drowned in Snake River at Keyesum, Ore.
accidental
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Jas. J. McCann Coroner
1-29 1921 (Address) Weiser Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Churchhill Iowa — DATE OF BURIAL ..... 19.....

20. UNDERTAKER: Northam & McCann — ADDRESS: Weiser Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 2—1921

CERTIFICATE OF DEATH

State of Idaho
STATE BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Washington
Registration District No.
Primary Registration District No.
File No. 33237
City of Cambridge (No. ..... St.)
Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Robert Emmet McBride

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Nov (Month) 26 (Day) 1876 (Year)

7. AGE: 44 Yrs. 2 Mos. 16 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Washington

10. NAME OF FATHER: Michael McBride

11. BIRTHPLACE OF FATHER (State or Country): Ireland

12. MAIDEN NAME OF MOTHER: Jane Calvert

13. BIRTHPLACE OF MOTHER (State or Country): ~~Ohio~~ St Johns NB

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Frank McBride
(Address)

15. Filed 2/18/21 19.... W. W. Wilkerson Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 12 (Day) 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 11/21 19 21, to 2/12 19 21
that I last saw h... alive on 2/11/ 19 21
and that death occurred on the date stated above, at 7 P. M.
The CAUSE OF DEATH* was as follows:
Tuberculosis
Don't Know (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Pleurisy
..... (Duration) ..... yrs. ..... mos. 21 ds.
(Signed) E. A. Wilkerson M. D.
2/15 19 21 (Address) Cambridge Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Cambridge — DATE OF BURIAL: Feb 15 19 21

20. UNDERTAKER: A. Henderson — ADDRESS: Cambridge

Every item of information should be carefully supplied. AGE must be given EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

INTERMOUNTAIN-FORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33238
Registered No. .....

Registration District No. .....
Primary Registration District No. .....
(No. ....., ... St.)

1. PLACE OF DEATH.
County of Elmore Wyoming
City of Elk River

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Gladys Laurette Mack

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Child
6. DATE OF BIRTH. June (Month) 25th (Day) 1920 (Year)
7. AGE ..... Yrs. 4 Mos. 12 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....
9. BIRTHPLACE (State or Country) Elk River
10. NAME OF FATHER Columbus Mack
11. BIRTHPLACE OF FATHER (State or Country) Wyoming
12. MAIDEN NAME OF MOTHER Gladys Smith
13. BIRTHPLACE OF MOTHER (State or Country) North Dakota
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. Gladys Mack
(Address) Elk River Idaho
15. Filed Nov. 11th 1920 Mrs. F. C. McConnell Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Nov (Month) 7 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Nov 2 1920, to Nov 6 1920, that I last saw her alive on Nov 6th 1920, and that death occured on the date stated above, at 7 A. M.
The CAUSE OF DEATH* was as follows:
Mucous Colitis
(Duration) ..... Yrs. ..... mos. 5 ds.
Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) F. P. McConnell M. D.
Nov 15 1920 (Address) Elk River Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Elk River — DATE OF BURIAL: Nov. 8 1920
20. UNDERTAKER — ADDRESS

SYMS - YORK CO., PTRS. & BORS. 24654

OCCUPATION is very important

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33286

Registration District No. .....
Primary Registration District No. .....
Registered No. .....

RECEIVED
APR 7 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Adams
City of Mesa (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Parsons Seymour
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Caucasian
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: July (Month) 2 (Day) 1872 (Year)

7. AGE: 47 Yrs. 5 Mos. 16 ds.
IF LESS than 1 day: how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer & Orchardist
(b) General nature of industry, business or establishment in which employed (or employer): Orchard

9. BIRTHPLACE (State or Country): New York State

10. NAME OF FATHER: George R. Seymour

11. BIRTHPLACE OF FATHER (State or Country): New York State

12. MAIDEN NAME OF MOTHER: Jennie Parsons

13. BIRTHPLACE OF MOTHER (State or Country): New York State

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maude N. Seymour
(Address) Mesa Idaho

15. Filed Dec 21 1920
W M Brown
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I ~~attended deceased from~~ was called on Dec 18 1920 to ..... 19....., that I last saw him alive on Dec 15 1920, and that death occurred on the date stated above, at 6:30 P.M.

The CAUSE OF DEATH* was as follows:
Overcome with smoke and body burned

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary): None

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W M Brown M. D.
Dec 20 1920 (Address) Caldwell

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Courtland No 4
DATE OF BURIAL: ..... 19.....

20. UNDERTAKER: Bookham & McCann
ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-18

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33294
Registered No. .....

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier (No. ..... St.)
Registration District No 52
Primary Registration District No 2136
If death occurs away from usual residence, give facts called for under special information.
2. FULL NAME Baby Sundeland.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED APR 1 1920 BUREAU OF STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant
6. DATE OF BIRTH. Mar. (Month) 21 (Day) 1920 (Year)
7. AGE ..... Yrs. ..... Mos. ..... ds. IF LESS than 1 day how many 6½ hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): .....
9. BIRTHPLACE (State or Country): Idaho.
10. NAME OF FATHER: Richard Sundeland,
11. BIRTHPLACE OF FATHER (State or Country): Colorado.
12. MAIDEN NAME OF MOTHER: LaWanta Huebner.
13. BIRTHPLACE OF MOTHER (State or Country): Nebraska
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Richard L. Sundeland
(Address) Montpelier Idaho
15. Filed 4-1-1920 N. H. Kemp Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH 3 (Month) 22 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from 3-21-1920 to 3-22-1920 that I last saw him alive on 3-21-1920 and that death occured on the date stated above, at 12 30 M.
The CAUSE OF DEATH* was as follows:
Pneumonia Bronchitis
Baby.
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Dr. F. Eccleston M. D.
3-22-1920 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Montpelier, Idaho — DATE OF BURIAL: 3-22-1920
20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24858

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33296
Registered No.

RECEIVED
APR 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH. Registration District No. 52
County of Bear Lake Primary Registration District No. 2136
City of Montpelier (No.) St.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Anna Maria Hymas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Married

6. DATE OF BIRTH
May (Month) 3 (Day) 1875 (Year)

7. AGE
45 yrs. 7 mos. 2 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work Home Keeping
(b) General nature of industry business, or establishment in which employed (or employer)

9. BIRTHPLACE
(State or Country) Switzerland

10. NAME OF FATHER Fredrick Aegerter

11. BIRTHPLACE OF FATHER
(State or Country) Switzerland

12. MAIDEN NAME OF MOTHER Catherina Lehman

13. BIRTHPLACE OF MOTHER
(State or Country) Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David M Hymas
(Address) Montpelier Idaho

15.
Filed 4-1- 1921 M Vickers
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
12 (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 1920 to Dec 4 1920
that I last saw her alive on Dec 4 1920
and that death occurred on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:
Chronic Valvular Heart Disease

(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) M. D.
8 1920 (Address)

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Montpelier, Idaho	Dec 8 1920

20. UNDERTAKER	ADDRESS
F. M. Williams	Montpelier, Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & EDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 52
Primary Registration District No. 2136
File No. 33297
County of Bear Lake.
City of Montpelier (No. St.)
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Sr. Clyde H. Sindle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Don't know

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 40 or 45 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. M. Williams
(Address) Montpelier Idaho

15.
Filed 4-1- 1917 N. T. Kerr
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Asphyxia. Found in Bunks of Refrigerator Car, Asphyxiated by fumes of Charcoal gas from Coal
(Duration) ~~cut~~ yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Williams Coroner M. D.
19 (Address) Montpelier, Idaho.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier — DATE OF BURIAL: Dec 18 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33298
Registered No.

1. PLACE OF DEATH
Registration District No. 52
Primary Registration District No. 2136
County of Bear Lake
City of Montpelier (St.)
If death occurs away from usual residence, give facts called for under special information.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED
APR 11 1927
BUREAU OF VITAL STATISTICS

2. FULL NAME Sr. Felipe Aguilar

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Mexican
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: ..... (Month) ..... (Day) 1 (Year)

7. AGE: 17 to 20 yrs. — mos. — ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER: Calletano Aguilar

11. BIRTHPLACE OF FATHER (State or Country): Mexico

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Mexico

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) F. M. Williams
(Address) Montpelier Idaho

15. Filed 4-1- 1927 W H Lang Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec. (Month) 17 (Day) 1927 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Asphyxia. Found in Bunker of Refrigerator Car. Asphyxiated by Charcoal gas fumes from car heater (Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. M. Williams Coroner M. D.
Dec 28 1927 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier | DATE OF BURIAL: Dec 18 1927
20. UNDERTAKER: F. M. Williams | ADDRESS: Montpelier Idaho

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.
MARGIN RESERVED FOR BINDING

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED APR 11 1921 BUREAU OF STATISTICS

Registration District No. 52
Primary Registration District No. 2136
File No. 33299
Registered No.

1. PLACE OF DEATH.
County of Bear Lake
City of Montpelier
(No. ....., St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Mervyan A Kenny

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH: July (Month) 9 (Day) 1906. (Year)

7. AGE: 14 yrs. 5 mos. 11 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Schools
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: David J Kenny

11. BIRTHPLACE OF FATHER (State or Country): Idaho.

12. MAIDEN NAME OF MOTHER: Emma Kenny.

13. BIRTHPLACE OF MOTHER (State or Country): Idaho.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) David J Kenny
(Address) Bern Idaho.

15.
Filed 4-1-1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
Dec (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1920 to Dec 20 1920
that I last saw h... alive on Dec 20 1920
and that death occurred on the date stated above, at 8 P M.
The CAUSE OF DEATH* was as follows:
Pneumonia Appendicitis
(Duration) ..... yrs. ..... mos. ..... ds.
Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) Leo V Priestley M D.
12-21 1920 (Address) Montpelier Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Bern Idaho — DATE OF BURIAL: Dec 23 1920

20. UNDERTAKER: F. M. Williams — ADDRESS: Montpelier Idaho

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED APR 11 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 52
County of Bear Lake Primary Registration District No. 2136
City of Montpelier (No. ..... St.) File No. 33300
If death occurs away from usual residence, give facts called for under special information. Registered No. .....
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Baby Crave.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Infant

6. DATE OF BIRTH: Dec (Month) 22 (Day) 1920 (Year)

7. AGE: ..... yrs. ..... mos. 1 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry business, or dstablishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: D. W. Crave

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Amanda Hill

13. BIRTHPLACE OF MOTHER (State or Country): Wyoming

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Carrie Hill
(Address) Pegram Idaho

15. Filed 4-1- 1921 H. N. Kelley Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Dec (Month) 23 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 22 1920, to Dec 23 1920, that I last saw her alive on Dec 23 1920, and that death occurred on the date stated above, at 10 A M.

The CAUSE OF DEATH* was as follows:
Asphyxiation - Failure of Respiratory Centre

(Duration) ..... yrs. ..... mos. 1 ds.
Contributory Premature Birth
(Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Huckaby M. D.
4-1 1921 (Address) Montpelier Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Pegram Ida. DATE OF BURIAL: Dec 24 1920

20. UNDERTAKER: F. M. Williams ADDRESS: Montpelier

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., PTRS. & BDRS. 19760

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
APR 1 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Bear Lake
City of Montpelier (St.)
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 52
Primary Registration District No. 2131

File No. 33302
Registered No.
If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Helen Knuth

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH: Dec. (Month) 9 (Day) 1919 (Year)

7. AGE: 1 yrs. mos. 21 ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Knuth

11. BIRTHPLACE OF FATHER (State or Country): Switzerland

12. MAIDEN NAME OF MOTHER: Rose Groesjean

13. BIRTHPLACE OF MOTHER (State or Country): Switzerland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Knuth
(Address) Montpelier, Idaho

15.
Filed 4-1-1921
A. H. Keeys
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: 12 (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12-29-1920, to 12-29-1920 that I last saw her alive on 12-29-1920 and that death occurred on the date stated above, at 12 30 M.

The CAUSE OF DEATH* was as follows:
Convulsions Intestinal Catarrh
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.
(Signed) Geo. E. Gubler M. D.
12-30 1920 (Address) Montpelier

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Montpelier
DATE OF BURIAL: Dec 31 1920

20. UNDERTAKER: F. M. Williams
ADDRESS: Montpelier Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 19760

FORM V. S. No. 5-25 M. 1-16-13 (12)

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 121
Primary Registration District No. 2194
File No. 33320
Registered No. 32

1. PLACE OF DEATH.
County of Bingham
City of
(No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Frederick Everett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Oct 29 (Month) (Day) 1860 (Year)

7. AGE: 59 Yrs. 11 Mos. 19 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)...

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Everett

11. BIRTHPLACE OF FATHER (State or Country): Russia

12. MAIDEN NAME OF MOTHER: Helen Jaeger

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) J. C. Everett
(Address)

15. Filed March 26 1921 Mrs Nalen E. Pate Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Aug 10 (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 191... to ..... 191....., that I last saw h... alive on Aug 10 191..., and that death occured on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Apoplexy

Heart Trouble (Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration 2 yrs.) ... mos. ... ds.

(Signed) T. C. Webb M. D.

(Address) Shelley Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rose Hill — DATE OF BURIAL: Aug 12 1920

20. UNDERTAKER: Duff & Hayes — ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNUM - YORK CO., PTRS. & BDRS. 24653

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

RECEIVED APR 8 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 133359

Registered No. 80

1. PLACE OF DEATH. Registration District No. 80
County of Bonner Primary Registration District No. 2157
City of Hope St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Walter M. Crandall

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May 8 (Month) (Day) 1871 (Year)

7. AGE: 49 yrs. 7 mos. 7 ds. IF LESS than 1 day how many ..... hrs. or ..... mins.)

8. OCCUPATION
(a) Trade, profession or particular kind of work Shoe Cobler
(b) General nature of industry business, or dstablishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Wisconsin

10. NAME OF FATHER Walter M. Crandall.

11. BIRTHPLACE OF FATHER (State or Country) Wisconsin

12. MAIDEN NAME OF MOTHER Emma Carpenter.

13. BIRTHPLACE OF MOTHER (State or Country) Wisconsin.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant)
(Address)

15. Filed March 29 1921 J. H. Lenon Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December 15th 1920 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 13 1920 to Dec 15th 1920 that I last saw h alive on Dec 14 1920 and that death occurred on the date stated above, at 12 M.

The CAUSE OF DEATH* was as follows:
Bronchial Pneumonia

(Duration) 2 Days

Contributory (Secondary) Indigestion

(Duration) yrs. mos. 1 0 ds.

(Signed) M. M. Kinnick M. D.

3-29 1921 (Address) Hope

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Hope Cemetary. DATE OF BURIAL: Dec 17 1921

20. UNDERTAKER: M. F. Yakley. ADDRESS: Hope Idaho.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SDRS. 19760

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 73
Primary Registration District No. 2110
File No. 22068
Registered No. 5268

1. PLACE OF DEATH
County of Bonneville
City of Idaho Falls
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME (No. Lillian M. St.) ~~Baby~~ Holden

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Infant (Write the word.)

6. DATE OF BIRTH: Nov (Month) 13 (Day) 1920 (Year)

7. AGE: 0 Yrs. 0 Mos. 0 ds.
IF LESS than 1 day how many 9½ hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: —
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho Falls

10. NAME OF FATHER: Joseph N Holden

11. BIRTHPLACE OF FATHER (State or Country): Idaho Falls

12. MAIDEN NAME OF MOTHER: Lillian Barrows

13. BIRTHPLACE OF MOTHER (State or Country): Ogden Ut

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J Holden
(Address) City

15. Filed 2/4 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 13 1920 to Nov. 14, 1920 that I last saw h... alive on ... 19..., and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Unknown.
(child premature)

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) John O. Mullar M. D.
11/17 1920 (Address) Idaho Falls Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Idaho Falls — DATE OF BURIAL: 11/17 1920

20. UNDERTAKER: C E Dimmock — ADDRESS: Ida Falls

Dr. 20 mella

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33369

Registered No. 1

1. PLACE OF DEATH,
County of Bonneville
City of Ida Dell
(No. Arcadia St.)
Registration District No. 73
Primary Registration District No. 2170

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Virginia Wright

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Married (Write the word.)

6. DATE OF BIRTH: Aug (Month) 19 (Day) 1890 (Year)

7. AGE: 30 Yrs. 3 Mos. 19 ds.
IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At Home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Rexburg Ida

10. NAME OF FATHER: D. W. Charles

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Ella Green

13. BIRTHPLACE OF MOTHER (State or Country): Wales

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) J. D. Charles
(Address) Rexburg, Ida

15. Filed 2/8 1921 [illegible] Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 30 1920 to Dec 31 1920 that I last saw h[illegible] alive on Dec 31 1920, and that death occurred on the date stated above, at 5:00 M.

The CAUSE OF DEATH* was as follows:
Following Operation for Acute Inflammatic appendicitis
(Duration) ... Yrs. ... mos. 6 ds.
Contributory (Secondary)
(Duration) ... yrs. ... mos. ... ds.

(Signed) H Ray Harkness M. D.
Dec 31 1920 (Address) Idaho Falls Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Rexburg
DATE OF BURIAL: Jan 1 1920

20. UNDERTAKER: [illegible]
ADDRESS: Idaho Falls

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

D. Hatch

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2127
File No. 33456
Registered No.

1. PLACE OF DEATH
County Fremont
City of St Anthony
(No. , St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emma Walker Grover

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widowed

6. DATE OF BIRTH: March 15th-1846.
(Month) (Day) (Year)

7. AGE: 84 Yrs. 9 Mos. ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House wife
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): England

10. NAME OF FATHER: William Walker

11. BIRTHPLACE OF FATHER (State or Country): London, England.

12. MAIDEN NAME OF MOTHER: Unkown

13. BIRTHPLACE OF MOTHER (State or Country): Unkown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) A. L. Grover
(Address) Garland Utah

15. Filed June 10 1920
W. D. Weeks
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 3 (Day) -20 19 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 1920 to Dec. 19..., that I last saw her alive on Dec 2 1920, and that death occurred on the date stated above, at ....M.
The CAUSE OF DEATH* was as follows:

Senility
(Duration) Yrs. mos. ds.

Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) J. Frank Watkins M. D.
1920 (Address) St Anthony Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Garland Utah
DATE OF BURIAL 19...

20. UNDERTAKER: Taylor Eliason & G
ADDRESS St Anthony

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2179
File No. 33457
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Martin L. Bird
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Jan (Month) 8 (Day) 8[illegible]6 (Year)

7. AGE: 74 Yrs. 10 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: John Bird

11. BIRTHPLACE OF FATHER (State or Country): England

12. MAIDEN NAME OF MOTHER: Dauphenais

13. BIRTHPLACE OF MOTHER (State or Country): England

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) G. W. Bird
(Address) St Anthony Ida

15. Filed Jan 10 1921
W. Dewey
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 1 (Month) 2 (Day) 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 5/17/1920, to 1/2/1920, that I last saw him alive on 1/2/1920, and that death occurred on the date stated above, at 11 A.M.
The CAUSE OF DEATH* was as follows:
Bronchial asthma
(Duration) 5 Yrs. — mos. — ds.
Contributory (Secondary): none
(Duration) — yrs. — mos. — ds.
(Signed) Jno R Gray M. D.
1/6 1920 (Address) St Anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Teton Cdy — DATE OF BURIAL: 1/8/1920

20. UNDERTAKER: Edison-Taylor — ADDRESS: St Anthony Ida

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 99
Primary Registration District No. 2177
File No. 33458
Registered No.

1. PLACE OF DEATH
County of Fremont
City of St Anthony
(No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Maria Nelson Hansen
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widow (Write the word.)

6. DATE OF BIRTH: March (Month) 16 (Day) 1844 (Year)

7. AGE: 76 Yrs. 8 Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer): —

9. BIRTHPLACE (State or Country): Denmark

10. NAME OF FATHER: —

11. BIRTHPLACE OF FATHER (State or Country): Denmark

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Denmark

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) W. M. Hansen
(Address) St Anthony Idaho

15. Filed Jan 10 19 21 — W D Lewis, Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: December (Month) 12 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1st 19 attended she 19, that I last saw h[illegible] alive on 19, and that death occurred on the date stated above, at 6:40 P. M.
The CAUSE OF DEATH* was as follows:
Senility
(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) Dont Know
(Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W D Wm Local Reg M. D.
19 ..... (Address) .....

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death 15 yrs. ..... mos. ..... days. In the State 15 yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence St Anthony Idaho

19. PLACE OF BURIAL OR REMOVAL: Logan Utah — DATE OF BURIAL: Dec. 15 1920

20. UNDERTAKER: Taylor-Kleaver Co. — ADDRESS: St Anthony

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremont

City of St anthony

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 99

Primary Registration District No. 177

(No. ..... St.)

File No. 32459

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Kate Davis

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: female

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: 7 (Month) 15 (Day) 1884 (Year)

7. AGE: 36 Yrs. 5 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: housekeeper

(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): utah

10. NAME OF FATHER: John L Justice

11. BIRTHPLACE OF FATHER (State or Country): s carlland

12. MAIDEN NAME OF MOTHER: annie Sarenson

13. BIRTHPLACE OF MOTHER (State or Country): utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) .....

(Address) .....

15. Filed Jan 10 1921

W. B. Lee

Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/14/1920, to 12/18/1920 that I last saw her alive on 12/17/1920, and that death occurred on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

septicemia

(Duration) Yrs. 1 mos. 5 ds.

Contributory (Secondary): abortion

(Duration) yrs. mos. 7 ds.

(Signed) J. M. McCleary M. D.

12/20/1920 (Address) St anthony Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rigby — DATE OF BURIAL: 12/21/1920

20. UNDERTAKER: Edinson-Taylor — ADDRESS: St anthony

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
APR 6 1921
BUREAU OF STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33460
Registered No. .....

1. PLACE OF DEATH.
County of Gooding
City of Wendell
Registration District No 22
Registration District No 2028
St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Lehman Wilcox

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. May (Month) 17 (Day) 1865 (Year)

7. AGE: 54 Yrs. 10 Mos. 20 ds.
IF LESS than 1 day how many.....hrs. or .....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Carroll Co Ill

10. NAME OF FATHER Charles W. Wilcox

11. BIRTHPLACE OF FATHER (State or Country) Auburn N.Y.

12. MAIDEN NAME OF MOTHER Martha Ellen Knox

13. BIRTHPLACE OF MOTHER (State or Country) Polo Ill

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) A. L. Wilcox
(Address) Wendell Ida

15. Filed Apr 10 1920 E. L. Simonton Local Registrar

SYMS - YORK CO., PTRS. & BOBS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 7" (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1918, to Apr 7" 1920, that I last saw him alive on Apr 6" 1920, and that death occured on the date stated above, at 1 A M.

The CAUSE OF DEATH* was as follows:
Paralysis

(Duration) 3 Yrs. - mos. - ds.

Contributory (Secondary)
(Duration ..... Yrs. ..... mos. ..... ds.

(Signed) E. L. Simonton M. D.
4-10 1920 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida — DATE OF BURIAL: 4-9 1920

20. UNDERTAKER: Simpson — ADDRESS: Gooding

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-16-13

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CERTIFICATE OF DEATH.

RECEIVED APR 6 1921 BUREAU OF VITAL STATISTICS

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33461

Registered No. .....

1. PLACE OF DEATH.

County of Gooding — Primary Registration District No. 22

City of Wendell — Registration District No. 2018

(If death occurs away from usual residence, give facts called for under special information.)

2. FULL NAME Frank E. Barrett

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. (Month) Dec (Day) 22 (Year) 1875

7. AGE: 44 Yrs. 4 Mos. 6 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.)

8. OCCUPATION
(a) Trade, profession or particular kind of work... Physician
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Kansas

10. NAME OF FATHER Spencer P. Barrett

11. BIRTHPLACE OF FATHER (State or Country) Penn

12. MAIDEN NAME OF MOTHER Anna Elkin

13. BIRTHPLACE OF MOTHER (State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Sarah M. Barrett
(Address) Wendell Idaho

15. Filed Apr 30 1921 [illegible] Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (Month) Apr (Day) 28 1921 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 1 1915, to Apr 28 1920, that I last saw h. alive on Apr 27 1920, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) 8 Yrs. — mos. — ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

19..... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Wendell Ida — DATE OF BURIAL: Apr 29 1920

20. UNDERTAKER: Thompson — ADDRESS: Wendell

SYMS - YORK CO., PTRS. & BORS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33463

Registered No. .....

If death occurred in a hospital, institution or camp, give its NAME instead of street and, number.

1. PLACE OF DEATH.

County of Gooding

City of Wendell

If death occurs away from usual residence, give facts called for under special information.

Primary Registration District No. 2018

(No. ..... St.)

2. FULL NAME Phillip H. Gray

RECEIVED
APR 6 1921
BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Male	white	Married

6. DATE OF BIRTH. Dec (Month) 22 (Day) 1851 (Year)

7. AGE 68 Yrs. 1 Mos. 6 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work... Farmer
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Pennsylvania

10. NAME OF FATHER Do not know

11. BIRTHPLACE OF FATHER (State or Country) "

12. MAIDEN NAME OF MOTHER Do not know

13. BIRTHPLACE OF MOTHER (State or Country) "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Phillip H Gray
(Address) Wendell Ida.

15. Filed Apr 4" 1921 E L Simonton Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Jan (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1919, to Jan 28 1920, that I last saw him alive on Dec 28 1920, and that death occured on the date stated above, at 7 P M.

The CAUSE OF DEATH* was as follows:
Arterio sclerosis
and Heart failure

(Duration) 2 Yrs. — mos. — ds.

Contributory (Secondary) .....
(Duration ..... yrs. ..... mos. ..... ds.

(Signed) E L Simonton M. D.
4-30 1921 (Address) Wendell Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL Wendell Ida | DATE OF BURIAL Jan 30 1920

20. UNDERTAKER Thompson | ADDRESS Gooding Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & SORS. 24654

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33466
Registered No.

RECEIVED
APR - 4 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Idaho
City of White Bird (No. St.)
Registration District No. 104
Primary Registration District No.
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Sarah Reid

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: married (Write the word.)

6. DATE OF BIRTH: Feb (Month) 11 (Day) 1832 (Year)

7. AGE: 88 Yrs. 10 Mos. 22 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: House work -
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Aron Bolinger

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: - - - -

13. BIRTHPLACE OF MOTHER (State or Country): - - -

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Fred Reid
(Address)

15.
Filed ..... 19 .....
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 1 1920, to Nov 15 1920, that I last saw her alive on Nov 13 1920, and that death occurred on the date stated above, at 6 P M.

The CAUSE OF DEATH* was as follows:
General Decline
with Mitral insufficiency
(Duration) Yrs. 6 mos. ds.
Contributory (Secondary) —
(Duration) yrs. mos. ds.

(Signed) W A Foskett M. D.
Nov 17 1920 (Address) White Bird

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence White Bird

19. PLACE OF BURIAL OR REMOVAL: E S Hancock — DATE OF BURIAL: Nov 17 1920

20. UNDERTAKER: E S Hancock — ADDRESS: Grangeville

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

Form V. S. No. 5 20M.1-16-12

RECEIVED SEP 28 [illegible]
RECEIVED APR - 4 [illegible]
BUREAU OF V[illegible] STATISTICS

CERTIFICATE OF DEATH

Registration District No. 164

Primary Registration District No. .....

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33467

Registered No. .....

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Idaho

City of Pollock (or) .....St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John Thomas Hollenbeak

PERSONAL AND STATISTICAL PARTICULARS

3. SEX

4. COLOR OR RACE

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.) married

6. DATE OF BIRTH: February (Month) 24 (Day) 1853 (Year)

7. AGE: 67 yrs. 7 mos. 11 ds.

IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ..... Stockman
(b) General nature of industry business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Iowa

10. NAME OF FATHER Benjamin Hollenbeak

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER Malinda Wilkerson

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mary B Hollenbeak
(Address) Pollock Idaho

15.
Filed ..... 191... W. A. Foskett Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: December (Month) fifth (Day) 192[illegible] (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Chronic Interstitial Nephritis with enlarged prostate
(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) W A Foskett M. D.
19.... (Address) White Bird

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.

Where was disease contracted if not at place of death?.....

Former or usual residence.....

19. PLACE OF BURIAL OR REMOVAL: Riggins Cemetary | DATE OF BURIAL: Dec 7 192[illegible]

20. UNDERTAKER | ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 18760

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 33480
Registered No. 7

1. PLACE OF DEATH
County of Jefferson
City of Ririe
(No. ..... , ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Wanda Ruth Summers
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Infant

6. DATE OF BIRTH: Dec 6 (Month) (Day) 1920 (Year)

7. AGE: ..... Yrs. ..... Mos. 26 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Idaho

10. NAME OF FATHER: John Summers

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Dora Montgomery

13. BIRTHPLACE OF MOTHER (State or Country): Montana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) John Summers
(Address) Ririe, Idaho

15. Filed Mch 10 1921 Ray H Fisher Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 31 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 27 1920 to Dec 30 1920
that I last saw her alive on Dec 30 1920
and that death occurred on the date stated above, at 4a M.
The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) ..... Yrs. ..... mos. 3 ds.
Contributory (Secondary) Whooping Cough
(Duration) ..... yrs. ..... mos. 7 ds.

(Signed) Sam F. Bruce M. D.
1-2 1921 (Address) Ririe, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Ririe — DATE OF BURIAL: 1-2 1921

20. UNDERTAKER: W. L. Young — ADDRESS: Rigby

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2013
File No. 33542
Registered No. ____

1. PLACE OF DEATH
County of Minidoka
City of Rupert
(No. ____, ____ St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Verlie Goff

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Child (write the word.)

6. DATE OF BIRTH: Feb (Month) 9 (Day) 1911 (Year)

7. AGE: 9 Yrs. 3 Mos. 12 ds.
IF LESS than 1 day how many ____ hrs. or ____ min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business or establishment in which employed (or employer): ____

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: L. F. Goff

11. BIRTHPLACE OF FATHER (State or Country): Utah

12. MAIDEN NAME OF MOTHER: Almina Dalman

13. BIRTHPLACE OF MOTHER (State or Country): Utah

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) L. F. Goff
(Address) Rupert Idaho

15.
Filed Mar 5 1921 E. E. Elmore
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: May (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 29" 1920, to May 18 1920
that I last saw h.er alive on May 17 1920
and that death occurred on the date stated above, at 12 15 M.
The CAUSE OF DEATH* was as follows:
Endocarditis Chronic - Mitral insufficiency, Acute myocarditis
(Duration) ____ Yrs. 4 mos. ____ ds.
Contributory (Secondary) Acute Bright's Disease
(Duration) ____ yrs. 3 mos. ____ ds.
(Signed) Leland Fraser M. D.
May 9 1920. (Address) Rupert, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ days. In the State ____ yrs. ____ mos. ____ days
Where was disease contracted if not at place of death? ____
Former or usual residence ____

19. PLACE OF BURIAL OR REMOVAL | DATE OF BURIAL 19____

20. UNDERTAKER | ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 19
Primary Registration District No. 2013
(No. ..... St.)

File No. 33543
Registered No. 17

1. PLACE OF DEATH.
County of Minidoka
City of Paul

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Arthur Deem Jackson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov. (Month) 25 (Day) 1877. (Year)

7. AGE: 43 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri.

10. NAME OF FATHER: James R. Jackson.

11. BIRTHPLACE OF FATHER (State or Country): Kentucky.

12. MAIDEN NAME OF MOTHER: Ruth E. Root.

13. BIRTHPLACE OF MOTHER (State or Country): Ohio.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) O. L. Jackson
(Address) Rupert R. 1.

15.
Filed Mar. 5 1921 Ethel Evans
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
May (Month) 28 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 23 1920 to May 27 1920
that I last saw h[illegible] alive on May 28 1920
and that death occured on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Tick Fever,

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
5-29 1920 (Address) Rupert, Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: North Side Twin Falls
DATE OF BURIAL: 1921

20. UNDERTAKER: L. D. Galloway
ADDRESS: Burley Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
APR 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH. Registration District No. 70
County of Shoshone Primary Registration District No. 1011
City of Wallace (If not in incorporated city or village give township) 14 True St.)
File No. 33598
Registered No. 57

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Emmett L. Vanderwerker

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): widowed

6. DATE OF BIRTH. Dec (Month) 16 (Day) 1846 (Year)

7. AGE: 75 Yrs. 11 Mos. 4 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: merchant
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John Vanderwerker

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Sarah Lagrange

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs K. E. McLeod
(Address) Post Falls Ida

15. Filed Dec 1 1920 F. L. Jenkins Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 20 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov 16 1920 to Nov 20 1920 that I last saw h[illegible] alive on Nov 20 1920 and that death occured on the date stated above at ..... M.

The CAUSE OF DEATH* was as follows:
Cerebral embolism
(Duration) ..... Yrs. ..... mos. 4 ds.
Contributory (Secondary)
(Duration) ..... Yrs. ..... mos. ..... ds.

(Signed) Dr Mowery M.D.
11/22 1920 (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Missoula Mont. DATE OF BURIAL: Nov 23 1920

20. UNDERTAKER: P G Nesbitt ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

6788 - YORK CO., PTRS. & BDRS. 24858

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33599

Registered No. 38

1. PLACE OF DEATH.

County of Shoshone

City of Wallace

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
APR 3
BUREAU OF VITAL STATISTICS

Registration District No. 20

Primary Registration District No. 10

Sec.

2. FULL NAME A. P. Mann

If death occurred in a hospital, institution or camp, give its NAME instead of street and number. Providence Hospital

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Aug (Month) 6 (Day) 1861 (Year)

7. AGE: 58 Yrs. 3 Mos. 12 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Steamboat
(b) General nature of industry, business, or establishment in which employed (or employer): Captain

9. BIRTHPLACE (State or Country): Pa

10. NAME OF FATHER: A. P. Mann

11. BIRTHPLACE OF FATHER (State or Country): Pa

12. MAIDEN NAME OF MOTHER: Louisa Dodd

13. BIRTHPLACE OF MOTHER (State or Country): N. Jersey

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Della Mann
(Address) 2700 - 4th ave, Seattle

15. Filed Dec 1 1920 F L Zeuner Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 21 (Day) 1920 (Year)

I HEREBY CERTIFY, That I attended deceased from Aug 12 1920 to Nov 21 1920, that I last saw h[illegible] alive on Nov 21 1920 and that death occured on the date stated above, at 3300 M.

The CAUSE OF DEATH* was as follows:

Thrombosis Mesenteric artery

(Duration) ..... Yrs. ..... mos. 2½ ds.

Contributory (Secondary) Appendicitis

(Duration) ..... Yrs. ..... mos. 3 ds.

(Signed) Dr Mowry M. D.

11/22 1920 (Address) Wallace Ida

State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Seattle Wn. DATE OF BURIAL: Nov 23 1920

20. UNDERTAKER: E. J. Merritt ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & STRS. 24653

FORM V. S. No. 5-12 M. 6-15-17.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

RECEIVED
APR 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33600
Registered No. 37

1. **PLACE OF DEATH**
County of Shoshone Registration District No. 70
City of Wallace Registration District No. 11
If death occurs away from usual residence, give facts called for under special information. No. Wallace Hospital St.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. **FULL NAME** John Casey

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
M	W	Single

6. **DATE OF BIRTH.** ..... (Month) ..... 1 ..... (Day) ..... (Year)

7. **AGE** 55 Yrs. ~ Mos. ~ ds. IF LESS than 1 day how many .... hrs. or ..... min.?

8. **OCCUPATION**
(a) Trade, profession or particular kind of work Logger
(b) General nature of industry, business, or establishment in which employed (or employer)

9. **BIRTHPLACE** (State or Country) not given

10. **NAME OF FATHER** " "

11. **BIRTHPLACE OF FATHER** (State or Country) " "

12. **MAIDEN NAME OF MOTHER** " "

13. **BIRTHPLACE OF MOTHER** (State or Country) " "

14. **THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**
(Informant) Wallace Hospital
(Address) Wallace, Idaho

15. Filed Dec 9 1920 F L Jensen Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. **DATE OF DEATH** Dec (Month) 5 (Day) 1920 (Year)

17. **I HEREBY CERTIFY,** That I attended deceased from Nov. 26 1920 to Dec. 5 1920 that I last saw h.im alive on Dec. 5 1920 and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia, Hemorrhagic Type
Contributory (Secondary) Alcoholism
(Duration) 1 Yrs. 7 mos. ds.

(Signed) Howard C. Thurm M. D.
19 (Address) Wallace Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. **LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)**
At place of death ....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Wallace Ida	Dec 9 1920.
20. UNDERTAKER Hurtell & Co.	ADDRESS Wallace

FORM V. S. No. 5-12 M. 6-15-17.

RECEIVED
APR 5 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33601
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH
County of Shoshone
City of Wallace
If death occurs away from usual residence, give facts called for under special information.

Registration District No. 20
Registration District No. 18
(No. ..... St.)

2. FULL NAME Fredrick M. Russell

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. January (Month) 12 (Day) 1868 (Year)

7. AGE 52 Yrs. 10 Mos. 25 ds.
IF LESS than 1 day how many .... hrs. or .....min.?'

8. OCCUPATION
(a) Trade, profession or particular kind of work: Assayer
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): New York

10. NAME OF FATHER: John C. Russell

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Angeline Osgood

13. BIRTHPLACE OF MOTHER (State or Country): Vermont

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Chas. Keating
(Address) Wallace Ida.

15. 12/9-20
Filed ~~1/1/9~~ 1921 Geo. S. Lester Local Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 9th (Day) 20 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..... to .....191...
that I last saw h.....alive on .....191....
and that death occurred on the date stated above, at .....,....M.

The CAUSE OF DEATH* was as follows:
Suicide
cut throat
.....(Duration) ..... Yrs..... mos. ..... ds.
Contributory (Secondary) .....
.....(Duration) ..... Yrs..... mos. ..... ds.
(Signed) Geo. S. Lester M. D.
12-9-1920 (Address) Coeur d'Alene Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ....yrs.....mos....days. In the ,State....yrs.....mos.....days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: New York City N.Y. DATE OF BURIAL: 12/ 1920

20. UNDERTAKER: B.C. Corbett ADDRESS: Wallace

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED APR 5 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 23602

Registered No. .....

1. PLACE OF DEATH.

County of Shoshone Registration District No. 70

City of Wallace Providence Hospital Registration District No. 1011

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Catherine Costello

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
F.	white	widowed

6. DATE OF BIRTH.

..... (Month) ..... (Day) 1 (Year)

7. AGE

60 Yrs. — Mos. — ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... housework.

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE

(State or Country) Ireland

10. NAME OF FATHER Andrew King

11. BIRTHPLACE OF FATHER

(State or Country) Ireland

12. MAIDEN NAME OF MOTHER not known

13. BIRTHPLACE OF MOTHER

(State or Country) Ireland

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Florence Costello

(Address) Yakima Wash.

15.

Filed Dec 9 1920 F L Jennings Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH

Dec. (Month) 7th (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1912, to Dec 7 1920 that I last saw her alive on Dec 7 1920 and that death occured on the date stated above, at 7:30 M.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(Duration) 7 Yrs. mos. 14 ds.

Contributory (Secondary) Arterio Sclerosis

(Duration) 20 Yrs. mos. ds.

(Signed) Dr. McCurdy M. D.

Dec 8 1920 (Address) Wallace Ida.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL Wallace Ida — DATE OF BURIAL Dec 9 1920

20. UNDERTAKER Harry Thompson — ADDRESS Wallace Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BDRS. 24853

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33603

Registered No. 62

RECEIVED
APR 5 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.
County of Shoshone Registration District No. 70
City of Wallace Primary Registration District No. 1011
(If death occurs away from usual residence, give facts called for under special information.)
(Wallace Hospital)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Joseph Vibbani

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
m	w	Married

6. DATE OF BIRTH.
October (Month) 17 (Day) 1871 (Year)

7. AGE
49 Yrs. 1 Mos. 27 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work.....
(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE
(State or Country) Italy

10. NAME OF FATHER
Joseph Vibbani

11. BIRTHPLACE OF FATHER
(State or Country) Italy

12. MAIDEN NAME OF MOTHER
Mary Vibbani

13. BIRTHPLACE OF MOTHER
(State or Country) Italy

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Wallace Hospital
(Address) Wallace, Idaho

15. Filed Dec 16 1920 F. L. Jenne
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH
December (Month) 13 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 7 1920, to Dec 13 1920, that I last saw h in alive on Dec 13 1920, and that death occured on the date stated above, at 4:00 P.M.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration ..... yrs. 8 mos. 6 ds.

(Signed) Wm T. Smyth M. D.
19..... (Address) Wallace Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence Wallace Idaho

19. PLACE OF BURIAL OR REMOVAL: Wallace — DATE OF BURIAL: Dec 16 1920

20. UNDERTAKER: Harry Thompson — ADDRESS: Wallace

MARGIN RESERVED FOR BINDING

LEGIBLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS in plain terms, so that it may be properly classified. Exact statement CAUSE OF DEATH is very important. See instructions on back of certificate. of OCCUPATION

YORK CO., PTRS. & BDRS. 24653

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 12

Primary Registration District No.

File No. 33637

County of Basin

City of Garden Valley (St.)

Registered No. 1

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

FULL NAME Isaac Groarer.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: (Month) (Day) 1866 (Year)

7. AGE: 54 Yrs. Mos. ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farming

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Missouri

10. NAME OF FATHER: Hugh Groarer.

11. BIRTHPLACE OF FATHER (State or Country): Missouri

12. MAIDEN NAME OF MOTHER: Sarah Groarer.

13. BIRTHPLACE OF MOTHER (State or Country): " "

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Perry Groarer

(Address) Heyburn Idaho.

15.

Filed 19

Mrs E S Robison
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct 27 th (Month) (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 19 , to 19 , that I last saw h alive on 19 , and that death occurred on the date stated above, at M.

The CAUSE OF DEATH* was as follows: Instantly killed by falling from house.

(Duration) Yrs. mos. ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) G G Fitz M. D.

19 (Address) Twenty Eight

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence Garden Valley

19. PLACE OF BURIAL OR REMOVAL: Garden Valley

DATE OF BURIAL: Oct 29 1920

20. UNDERTAKER: none

ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

County of Clearwater

City of Elk River

Registration District No.....

Primary Registration District No.....

(No. ....., ... St.)

File No. 33641

Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Freeman A Roach

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. ..... (Month) ..... (Day) 1 (Year)

7. AGE: 87 Yrs. ..... Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Laborer Logging

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: M. S. Roach

11. BIRTHPLACE OF FATHER (State or Country): .....

12. MAIDEN NAME OF MOTHER: X

13. BIRTHPLACE OF MOTHER (State or Country): X

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) .....

(Address) .....

15.

Filed ..... 191.....

Mrs. F. P. McGinnis
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 2nd (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from June 2nd 1920, to ..... 191....., that I last saw h[illegible] alive on June 2nd 1920, and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Shock by Leg which
unloading logs in
mill pond

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) Inhaling water in lung

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) F. P. McGinnis M. D.

June 2 1920 (Address) Elk River Idaho

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Potlatch Idaho	June 1920
20. UNDERTAKER	ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24658

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
APR 21 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33767

Registered No. 16

1. PLACE OF DEATH

Registration District No. 73

County of Bonneville Primary Registration District No. 21 N-0

City of Idaho Falls (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Lauren Harry Jessup.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Dec (Month) 16. (Day) 1920. (Year)

7. AGE ..... Yrs. 4 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work... no

(b) General nature of industry, business, or establishment in which employed (or employer).....

9. BIRTHPLACE (State or Country) Idaho Falls Ida.

10. NAME OF FATHER Clyde Jessup.

11. BIRTHPLACE OF FATHER (State or Country) Ark.

12. MAIDEN NAME OF MOTHER Nettie Walker.

13. BIRTHPLACE OF MOTHER (State or Country) Mont.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Clyde Jessup

(Address) Idaho Falls Ida.

15. Filed May 4 1921 W. Kennard Local Registrar

SYMS - YORK CO., PTRS. & BOKS. 24658

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Dec (Month) 16 (Day) 1920. (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec 16 1921, to Dec 16 1921, that I last saw h..... alive on ..... 191..., and that death occured on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:

Pneumonia

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration ..... yrs. ..... mos. ..... ds.

(Signed) C. E. Rogers M. D.

19.... (Address) Idaho Falls.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Rose Hill Cemetery — DATE OF BURIAL: 4/17 1920.

20. UNDERTAKER: Cliff Hanes. — ADDRESS: Idaho Falls. Ida

Dr. Rogers

FORM V. S. No. 5-A—25 M. 1-19. RECEIVED MAY 4 1921 BUREAU OF VITAL STATISTICS STATE OF IDAHO

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33996
Registered No.

1. PLACE OF DEATH
Registration District No.
County of Adams
Primary Registration District No. Indian Valley
City of (No. , St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Alvin Curtis Smith

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White Grandma Smith

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: May (Month) 4 (Day) 1884 (Year)

7. AGE: 36 Yrs. 9 Mos. 2 ds.
IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: Jackson C Smith

11. BIRTHPLACE OF FATHER (State or Country): Indiana

12. MAIDEN NAME OF MOTHER: Susan Miller

13. BIRTHPLACE OF MOTHER (State or Country): Indiana

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Alfred D Smith
(Address) Indian Valley Idaho

15. Filed 5/21/21 19 W M Meeuan Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 5 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/5/21 19 21, to 12/7/21 19 21
that I last saw h alive on 19,
and that death occurred on the date stated above, at 2:30 P.M.
The CAUSE OF DEATH* was as follows:
Gunshot wound in head (Suicide)

(Duration) Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E A Wiseman M. D.
12/6 19 21 (Address) Cambridge, Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Indian Valley — DATE OF BURIAL: 12/8 1920

20. UNDERTAKER: J A Anderson — ADDRESS: Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 33997

Registration District No.
Primary Registration District No.
Registered No.

1. PLACE OF DEATH
County of Washington
City of Cambridge (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Joshua Edison Dumont
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

RECEIVED MAY 4 BUREAU OF VITAL STATISTICS

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: May (Month) 15 (Day) 1858 (Year)

7. AGE: 62 Yrs. 7 Mos. 2 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ethica Nebraska

10. NAME OF FATHER:

11. BIRTHPLACE OF FATHER (State or Country): Pennsylvania

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country): Pennsylvania

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant): Jos L Dumont
(Address): Cambridge Idaho

15. Filed 5/3/21 19.... W W Alderman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 12 (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 12/25 1920, to 12/27 1920, that I last saw h.im alive on 12/27 1920, and that death occurred on the date stated above, at 1 P M.

The CAUSE OF DEATH* was as follows:
Chronic Bright's disease
(Duration) 8 Yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) E A Wideman M. D.
12/29 1920 (Address) Cambridge Id

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death yrs. mos. days. In the State yrs. mos. days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Adventist	12/29 1920
20. UNDERTAKER	ADDRESS
J A Anderson	Cambridge

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 33998

Registered No.

1. PLACE OF DEATH

County of Adams

City of Indian Valley (If outside limits of city or village, give township.) St.)

If death occurs away from usual residence, give facts called for under special information.

Registration District No.

Primary Registration District No.

BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Infant Jackson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED
Female	White	Single (Write the word.)

6. DATE OF BIRTH: Nov (Month) 15 (Day) 1920 (Year)

7. AGE: ....Yrs....Mos. 5 hrs ds. IF LESS than 1 day how many....hrs. or....min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Adams Co Ida

10. NAME OF FATHER: Harry Jackson

11. BIRTHPLACE OF FATHER (State or Country): Kansas

12. MAIDEN NAME OF MOTHER: Katie Shaw

13. BIRTHPLACE OF MOTHER (State or Country): Idaho

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Harry Jackson
(Address)

15. Filed 5/3/21 19.... W. Whiteman Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 15 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Nov. 15 1920, to Nov. 15 1920, that I last saw h.s alive on Nov. 15 1920, and that death occurred on the date stated above, at 8 A.M.

The CAUSE OF DEATH* was as follows:
Premature Birth

(Duration) ....Yrs....mos. 5 hours ds.

Contributory (Secondary)

(Duration) ....yrs....mos....ds.

(Signed) Fa Ahmuty M. D.

1-7 1921 (Address) Mudvale

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death....yrs....mos....days. In the State....yrs....mos....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Indian Valley	Nov 4 1920
20. UNDERTAKER	ADDRESS
J. A. Anderson	Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STAR-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 34049
Registered No. 25

1. PLACE OF DEATH.
County of Ada
City of Kuna (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

Registration District No. 124
Primary Registration District No. 1202

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Edward E. Birchhead

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: Wh.
5. SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.): Married
6. DATE OF BIRTH. April (Month) 6 (Day) 1860 (Year)
7. AGE: 59 Yrs. 10 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?
8. OCCUPATION
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer):
9. BIRTHPLACE (State or Country): Maryland
10. NAME OF FATHER: Robert Birchhead
11. BIRTHPLACE OF FATHER (State or Country): Maryland
12. MAIDEN NAME OF MOTHER: Elenor Stallings
13. BIRTHPLACE OF MOTHER (State or Country): Maryland
14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Roy Musselman
(Address) Kuna Idaho
15. Filed Feb 18 1920 191
W. B. Steven
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Feb (Month) 16 (Day) 1920 (Year)
17. I HEREBY CERTIFY, That I attended deceased from Feb 10 1920, to Feb 16 1920, that I last saw him alive on Feb 16 1920, and that death occured on the date stated above, at 12 M.
The CAUSE OF DEATH* was as follows:
Influenza
(Duration) ..... Yrs. ..... mos. 6 ds.
Contributory (Secondary) Broncho Pneumonia
(Duration ..... yrs. ..... mos. ..... ds.
(Signed) Marion A. Farris M. D.
Feb 17 1920 (Address) Kuna Ada

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kuna Cemetary
DATE OF BURIAL: Feb 18 1920 191

20. UNDERTAKER: H. K. Robinson
ADDRESS: Nampa Idaho

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

BYNS - YORK CO., PTRS. & STRS. 24853

FORM V. S. No. 5-25 M. 1-16-18

34052

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

CERTIFICATE OF DEATH.

Registration District No. 124

Primary Registration District No. 2nd

File No. 1

Registered No. 24

RECEIVED
JUN 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH.

County of Ada

City of ..... (If outside limits of city or village give township) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Dale Marion Mericle

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. Nov 5 (Month) (Day) 1904 (Year)

7. AGE: 15 Yrs. 5 Mos. ..... ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Iowa

10. NAME OF FATHER: John Mericle

11. BIRTHPLACE OF FATHER (State or Country): Iowa

12. MAIDEN NAME OF MOTHER: Eva Russell

13. BIRTHPLACE OF MOTHER (State or Country): Iowa

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) John Mericle

(Address) Kuna, Idaho.

15. Filed 4/4/1920 191 .....

Wille Stevens
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH April (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 21 1920, to April 3 1920, that I last saw him alive on April 3 1920, and that death occured on the date stated above, at 9 A M.

The CAUSE OF DEATH* was as follows:

Pericardelis and
Myocarditis

(Duration) ..... Yrs. ..... mos. 43 ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) H J Calman M. D.

4-3 1920 (Address) Kuna

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Kuna Cemetery — DATE OF BURIAL: 4/5/20 191

20. UNDERTAKER: F. Robinson — ADDRESS: Nampa

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

STUB - YORK CO., PTRS. & STNRS. 24658

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 34235
Registered No. 27

1. PLACE OF DEATH
County of Jefferson
City of Roberts (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Oscar Benkenstein
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: W
5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): married

6. DATE OF BIRTH: Dec (Month) 1 (Day) 1886 (Year)

7. AGE: 34 Yrs. 2 Mos. 15 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Germany

10. NAME OF FATHER: Wm Benkenstein

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Emma Jehrt

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) .....
(Address) .....

15. Filed 5/10 1921 Ray H. Fisher, Local Registrar

SUMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 16 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Feb 15 1920 to Feb 16 1920 that I last saw h[illegible] alive on Feb 16 1920 and that death occurred on the date stated above, at 5 P.M.
The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Early D. Jones M. D.
2/18 1920 (Address) Roberts

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Roberts
DATE OF BURIAL: 2-18 1920

20. UNDERTAKER: C. E. Dunwoody
ADDRESS: Idaho Falls

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
MAY 20 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 98
Primary Registration District No. 2176
File No. 34236
Registered No. 28

1. PLACE OF DEATH

County of Jefferson
City of Roberts (No. ..... St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Rebecca McClure Gangee

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Widow

6. DATE OF BIRTH: Dec (Month) 14 (Day) 1859 (Year)

7. AGE: 60 Yrs. 11 Mos. 24 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Ill

10. NAME OF FATHER: ? Yeah

11. BIRTHPLACE OF FATHER (State or Country): Ill

12. MAIDEN NAME OF MOTHER: ?

13. BIRTHPLACE OF MOTHER (State or Country): ?

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ernest Douglas
(Address) Helena Mont.

15. Filed 5/10 1921 Ray H Fisher Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 8 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....
and that death occurred on the date stated above, at 7:30 a.m.
The CAUSE OF DEATH* was as follows:

Dead on arrival.
Probable Heart lesion

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earl D. Jones M. D.
12/10 1920 (Address) Roberts

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Forsyth, Mont. DATE OF BURIAL: 12/11 1920

20. UNDERTAKER: C. E. Dunwoody ADDRESS: Ida Fall

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

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FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
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BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH
County of Jerome
City of Jerome (St.)
Registration District No. 23
Primary Registration District No. 1017-2017
File No. 34248
Registered No.
If death occurs away from usual residence, give facts called for under special information.
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vincente Lopez

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single

6. DATE OF BIRTH. (Month) Unknown (Day) 1 (Year)

7. AGE: 23 Yrs. ..... Mos. ..... ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Mexico

10. NAME OF FATHER

11. BIRTHPLACE OF FATHER (State or Country)

12. MAIDEN NAME OF MOTHER

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) John F. Schmeckpfeffer
(Address) Jerome Ida

15. Filed May 26 1924 C. E. Piper Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Nov (Month) 4 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occured on the date stated above, at 8:30 A. M.
The CAUSE OF DEATH* was as follows:
accidental — Coroners inquest on file
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary)
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) John F. Schmeckpfeffer M. D.
Nov 8 1920 (Address) Jerome Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Jerome Cem — DATE OF BURIAL: Nov 8 1920

20. UNDERTAKER: D. A. L. Heinsen — ADDRESS: Jerome Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS - YORK CO., SYMS. & SONS. 24653

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 42

County of Kootenai

City of Spirit Lake, Ida. (No. ... St.)

RECEIVED
MAY 28 1921
BUREAU OF VITAL STATISTICS

File No. 34256

Registered No. ...

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Ruth I. Phillips

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
M	W	S

6. DATE OF BIRTH. Dec (Month) 14 (Day) 1919 (Year)

7. AGE ~~1~~ Yrs. 10 Mos. ... ds. IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work ...
(b) General nature of industry, business, or establishment in which employed (or employer) —

9. BIRTHPLACE (State or Country) Spirit Lake Idaho

10. NAME OF FATHER James E. Phillips

11. BIRTHPLACE OF FATHER (State or Country) Mich

12. MAIDEN NAME OF MOTHER Ida Anderson

13. BIRTHPLACE OF MOTHER (State or Country) Mich

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs. J. E. Phillips
(Address) Spirit Lake Ida

15. Filed 10/15 1920 Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct (Month) 14 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 10-14 1920, to 10-14 1920, that I last saw her alive on 10-14 1920, and that death occured on the date stated above, at 1.30 P M.

The CAUSE OF DEATH* was as follows:

Convulsions

(Duration) 2 Yrs. ... mos. 1/2 ds.

Contributory (Secondary) ...

(Duration ... yrs. ... mos. ... ds.

(Signed) Clark A. Donnelly M. D.

19... (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs ... mos ... days. In the State ... yrs ... mos ... days

Where was disease contracted if not at place of death? ...

Former or usual residence ...

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Spirit Lake Ida	Oct 15 1920

20. UNDERTAKER	ADDRESS
A. W. Gibson	Rathdrum Ida

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BOBS. 24654

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

34257

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED
MAY 28 1921
BUREAU OF STATISTICS

1. PLACE OF DEATH. Registration District No. .....
County of Kootenai Primary Registration District No. .....
City of Spirit Lake (No. ..... St.)
If death occurs away from usual residence, give facts called for under special information.

File No. .....
Registered No. .....
If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Vina N. Wheeler

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Fem
4. COLOR OR RACE: Wh.
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Nov (Month) 20 (Day) 1881 (Year)

7. AGE: 38 Yrs. 11 Mos. 7 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Utah

10. NAME OF FATHER: Nicklas Swanson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: Laura Falsley

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant): Henry F. Wheeler
(Address): Spirit Lake Idaho

15. Filed 5/25 1921
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct (Month) 27 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Oct 20 1920, to 10-27 1920, that I last saw h sw alive on Oct 20 1920, and that death occured on the date stated above, at ? M.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) Durat Yrs. — mos. — ds.

Contributory (Secondary) —

(Duration — Yrs. — mos. — ds.

(Signed) Earle A Friend M. D.

10-27 1920. (Address) Spirit Lake Idah

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Spirit Lake Idah — DATE OF BURIAL: Oct 27 1920

20. UNDERTAKER: O. W. Eaton Rathdrum — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

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MARGIN RESERVED FOR BINDING

SYMS - YORK CO., PTRS. & BORS. 24854

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED JUN 4 1921 BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

County of Fremda — Registration District No. 26

City of Malad (No. ..... St.) — Primary Registration District No. 2069

File No. 34340

Registered No. 14

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Baby Howard

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: Sept (Month) 30 (Day) 1920 (Year)

7. AGE: Yrs. 2 Mos. 3 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: child
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Holbrook, Idaho

10. NAME OF FATHER: Dewey Howard

11. BIRTHPLACE OF FATHER (State or Country): Rockland, Idaho

12. MAIDEN NAME OF MOTHER: Hazel Dunn

13. BIRTHPLACE OF MOTHER (State or Country): Kansas

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) R.M. Mauer
(Address)

15. Filed June 4 1921 — R.M. Mauer M.D. Local Registrar

SUMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec (Month) 3 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 30 1920, to Sept 30 1920 that I last saw h. him alive on Sept 30 1920 and that death occurred on the date stated above, at 6 a M.

The CAUSE OF DEATH* was as follows:
Patent Foramen Ovale

(Duration) Yrs. 2 mos. 3 ds.

Contributory (Secondary)

(Duration) yrs. mos. ds.

(Signed) R.M. Mauer M. D.

1921 (Address) Malad, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Brigham City, Utah — DATE OF BURIAL: Dec 4 1920

20. UNDERTAKER: Jesse Hoops — ADDRESS: Brig City, U

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 76
Primary Registration District No. 2153
File No. 34520
Registered No.

RECEIVED
JUL 11 1921
BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
County of Cassia
City of Macray (St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Florence Farley

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: F.

4. COLOR OR RACE: Wh

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Married

6. DATE OF BIRTH: 1 (Month) 1 (Day) 1860 (Year)

7. AGE: 62 Yrs. 9 Mos. 10 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Illinois

10. NAME OF FATHER: John J Farley

11. BIRTHPLACE OF FATHER (State or Country): Ohio

12. MAIDEN NAME OF MOTHER: Clemence Farley

13. BIRTHPLACE OF MOTHER (State or Country): Maine

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) H. B Goulety
(Address) Macray - Idaho

15. Filed 6 — 18 — 1921 R Nowacka
Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: 10 (Month) 10 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 9/10 1920, to 10/10 1920 that I last saw h er alive on 10/10 1920, and that death occurred on the date stated above, at 5 P M.

The CAUSE OF DEATH* was as follows:

Leucemia

(Duration) Several yrs. ..... mos. ..... ds.

Contributory (Secondary) Secondary Anemia

(Duration) 1 yrs. ..... mos. ..... ds.

(Signed) F. P. Richards M. D.

10/11 1920 (Address) Macray Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL ..... 19 .....
20. UNDERTAKER	ADDRESS

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 34824

Registered No. 8

1. PLACE OF DEATH

County of Elmore

City of Hill City (or Town) St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUN 15 1921
BUREAU OF VITAL STATISTICS

Registration District No. 24

Primary Registration District No. 2020

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Johnnie Johnson

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M.

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: June (Month) 15 (Day) 1[illegible]5 (Year)

7. AGE: 66 Yrs. ... Mos. ... ds.

IF LESS than 1 day how many ... hrs. or ... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Virmland Sweden

10. NAME OF FATHER: John Johnson

11. BIRTHPLACE OF FATHER (State or Country): Sweedin

12. MAIDEN NAME OF MOTHER:

13. BIRTHPLACE OF MOTHER (State or Country):

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Axel Johnson

(Address) Hill City Idaho

15. Filed 7-1-1921 J E Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 17 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ... 19..., to May 25 1921 that I last saw him alive on Dec 1920, and that death occurred on the date stated above, at ... M.

The CAUSE OF DEATH* was as follows:

accidental — froze to death on Light Creek

(Duration) ... Yrs. ... mos. ... ds.

Contributory (Secondary)

(Duration) ... yrs. ... mos. ... ds.

(Signed) J. E. Eaton Coroner

5/25 1921 (Address) Hill City Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ... yrs. ... mos. ... days. In the State ... yrs. ... mos. ... days

Where was disease contracted if not at place of death?

Former or usual residence: Light Canon

19. PLACE OF BURIAL OR REMOVAL: Hill City Cemetary — DATE OF BURIAL: 5-24 1921

20. UNDERTAKER: Axel Johnson, Hill City — ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

MARGIN RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH

Registration District No. 21

Primary Registration District No. 21

File No. 35007

County of Bonner

City of Blanchard (No. ..... St.)

Registered No. 43

If death occurs away from usual residence, give facts called for under special information.

RECEIVED SEP 6 1921 BUREAU OF VITAL STATISTICS

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME James Harold Litz

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Single (Write the word.)

6. DATE OF BIRTH: Sept. 27 (Month) (Day) 1920 (Year)

7. AGE: — Yrs. — Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business or establishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Thomas Gratton Litz

11. BIRTHPLACE OF FATHER (State or Country): Virginia

12. MAIDEN NAME OF MOTHER: Cora mae Freeman

13. BIRTHPLACE OF MOTHER (State or Country): Virginia

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Thos. G. Litz,

(Address) Blanchard, Idaho

15. Filed Sept 1 19 21 E. F. Gehlke Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Oct. 1 (Month) (Day) 19 21 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 27 1920, to Oct 1 1920, that I last saw h..... alive on ..... 19....., and that death occurred on the date stated above, at 11 P. M.

The CAUSE OF DEATH* was as follows:

Difficult Labor

Presentation

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. T. Phillips M. D.

19..... (Address) Wallace Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Blanchard, Idaho. DATE OF BURIAL: Oct. 3 19 21

20. UNDERTAKER: Thos. G. Litz ADDRESS: Blanchard, Ida.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

BORDER RESERVED FOR BINDING

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

FORM V. S. No. 5-25 M.-1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 35140
Registered No.

RECEIVED OCT 3 1921 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH

Registration District No. 83

County of Bannock Primary Registration District No.

City of Arimo (or Township) (St.)

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Dorothy Rust

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Female

4. COLOR OR RACE: White

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)

6. DATE OF BIRTH: Dec 1 (Month) 11 (Day) 1918 (Year)

7. AGE: 1 Yrs. 9 Mos. 7 ds.

IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work

(b) General nature of industry, business or establishment in which employed (or employer)

9. BIRTHPLACE (State or Country) Bannock Co Idaho

10. NAME OF FATHER albert Rust.

11. BIRTHPLACE OF FATHER (State or Country) Switzerland.

12. MAIDEN NAME OF MOTHER Katherin Fink,

13. BIRTHPLACE OF MOTHER (State or Country) Saxon mch.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert Rust

(Address) Arimo, Idaho

15. Filed 9-29-1921 J. J. Harrington Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Sept. (Month) 18 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept. 4 1920, to Sept. 18, 1920, that I last saw her alive on Sept. 19, 1920, and that death occurred on the date stated above, at 4:40 AM.

The CAUSE OF DEATH* was as follows:

Acute Enteric Intoxication

(Duration) Yrs. mos. 18 ds.

Contributory (Secondary) None

(Duration) yrs. mos. ds.

(Signed) J. J. Harrington M. D.

9-19-1920 (Address) Downey, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Arimo, Idaho. DATE OF BURIAL: Sept. 19 1920

20. UNDERTAKER ADDRESS

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

35280

STATE BOARD OF HEALTH FILE NO.

STATE OF ~~UTAH~~ IDAHO—DEATH CERTIFICATE

1 PLACE OF DEATH

County

Precinct or Village or City: Ranch at Holbrook Idaho

(No. , St.; Ward.) (If death occurred in a hospital or institution give its NAME instead of street and number.)

2 FULL NAME: Susan Dewey Howard

(a) Residence. No. St., Ward. (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (WRITE the word)
Male	White	Child

5a IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF (OR) WIFE OF —

6 DATE OF BIRTH: Sept 30, 1918 (Month) (Day) (Year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Holbrook Idaho
(State or country)

PARENTS

10 NAME OF FATHER: Isa Dewey Howard

11 BIRTHPLACE OF FATHER (State or country): Dewey Apache Co. Ariz

12 MAIDEN NAME OF MOTHER: Hazel Dunn

13 BIRTHPLACE OF MOTHER (State or country): Kansas

14 INFORMANT: Lita Young
(Address) Brigham

15 FILED Aug 15 1921 J. W. Almond REGISTRAR

REGISTERED NUMBER — NO. OF BURIAL PERMIT

21 — 22

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: Dec 3 - 1920 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 , that I last saw h alive on , 19 , and that death occured, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. A. Strangquist, M. D.

12/14, 1920 (Address) Brigham Ut.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Brigham	Dec 4 - 1920
20 UNDERTAKER	ADDRESS
Jesse Bakojis	Brigham

READ CAREFULLY INSTRUCTIONS ON BACK OF CERTIFICATE

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8-209 D
V. S. No. 98

UTAH STATE BOARD OF HEALTH
OFFICE OF THE SECRETARY AND
STATE REGISTRAR OF VITAL STATISTICS
T. B. BEATTY, M. D.
SALT LAKE CITY

July 13, 1921.

RECEIVED
JUL 15 1921
BUREAU OF VITAL
STATISTICS

Bureau of Vital Statistics,
State Board of Health,
Boise, Idaho.

Dear Sirs:-

We are sending you herewith a certificate of the death of Preston Dewey Howard which we received from our registrar at Brigham City where the child was buried. We are informed that the death occurred at Holbrook, Idaho, and the parents brought the body to Brigham City for burial. The enclosed certificate was made out bythe undertaker at Brigham and upon its receipt at this office, we communicated with our registrar instructing her to take the matter up with the undertaker and ascertain whether a certificate was filed in Idaho and if not to request the undertaker to send your board a certificate. We have been unable to ascertain whether a certificate was filed in Idaho and we are sending you the certificate we received from Brigham City.

Yours very truly,

Sign as State Registrar. T. B. Beatty
State Registrar.

FORM V. S. No. 5-25 M. 1-16-13

RECEIVED
OCT 31 1921
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 35612

Registered No. .....

Registration District No. 6 5

Primary Registration District No. 2145

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

1. PLACE OF DEATH.

County of Latah.

City of 10 miles W of Potlatch.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Infant Harned.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male.

4. COLOR OR RACE: White.

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Single.

6. DATE OF BIRTH. Dec. (Month) 29. (Day) 1920 (Year)

7. AGE: ✓ Yrs. ✓ Mos. ..... ds.

IF LESS than 1 day how many 5 hrs. or ..... min.)

8. OCCUPATION

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Idaho.

10. NAME OF FATHER: Wade H. Wynne.

11. BIRTHPLACE OF FATHER (State or Country): Kansas.

12. MAIDEN NAME OF MOTHER: Rosie Kidwell.

13. BIRTHPLACE OF MOTHER (State or Country): California.

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Wade H. Wynne.

(Address) Palouse Wash.

15. Filed Sept. 30th 1921 Dr. J. W. Thompson Local Registrar

SYMS - YORK CO., PTRS. & SORS. 24654

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Dec. (Month) 29 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Dec. 25 1921, to ✓ 191..., that I last saw h ✓ alive on ✓ 191..., and that death occured on the date stated above, at 10 P. M.

The CAUSE OF DEATH* was as follows:

Premature birth.

no doctor in attendance.

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration ..... yrs. ..... mos. ..... ds.

(Signed) J. W. Thompson M. D.

9/30/1921 (Address) Potlatch.

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days

Where was disease contracted if not at place of death?.....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL: Freese Cemetery — DATE OF BURIAL: Oct 1st 1921

20. UNDERTAKER: Parents. — ADDRESS: Palouse - Wash

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

Registration District No. 164
Primary Registration District No. 2182
File No. 36600
Registered No.

1. PLACE OF DEATH.
County of Idaho
City of ~~Bryans~~ Lucile (No. ....., ... St.)
If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Harry Southard

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: Male
4. COLOR OR RACE: White
5. SINGLE, MARRIED, WIDOWED OR DIVORCED: Widower (write the word)

6. DATE OF BIRTH: May (Month) 21 (Day) 1850 (Year)

7. AGE: 70 yrs. 5 mos. 29 ds.
IF LESS than 1 day how many .....hrs. or .....mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Miner
(b) General nature of industry business, or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Green Lake Co. Wis.

10. NAME OF FATHER: Edward Southard

11. BIRTHPLACE OF FATHER (State or Country): New York

12. MAIDEN NAME OF MOTHER: Mary E. Walbridge

13. BIRTHPLACE OF MOTHER (State or Country): New York

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James A. Carr.
(Address) Lucile - Ida.

15.
Filed ..... 191... W. A. Foskett
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH: Nov (Month) - 20 (Day) - 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw h..... alive on ..... 191...,
and that death occurred on the date stated above, at ..... M.

The CAUSE OF DEATH* was as follows:
Crushed by Cave-in in Mining Tunnel

(Duration) ..... yrs. ..... mos. ..... ds.

Contributory (Secondary)
(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
19.... (Address) .....

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days. In the State.....yrs.....mos.....days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL ~~OR REMOVAL~~: John Day — DATE OF BURIAL: 11-23-1920

20. UNDERTAKER: None — ADDRESS:

GYMS - YORK CO., PTRS. & BDRS. 18760

FORM V. S. No. 5-A—25 M. 1-19.

RECEIVED
APR 5 1922
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 37110

Registered No.

1. PLACE OF DEATH

County of Bannock

City of Pocatello (No. [illegible] St.)

Registration District No. 3160

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME James C. Nelson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
Male	White	Married

6. DATE OF BIRTH Sept 11 1857
(Month) (Day) (Year)

7. AGE 63 Yrs. 1 Mos. 9 ds.
IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country) Denmark

10. NAME OF FATHER Mathias Nelson

11. BIRTHPLACE OF FATHER (State or Country) Denmark

12. MAIDEN NAME OF MOTHER unknown

13. BIRTHPLACE OF MOTHER (State or Country) unknown

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James C. Nelson
(Address) Pocatello Ida

15. Filed Oct-13-1922 H. Hostetler
Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct 20 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....
that I last saw h..... alive on ..... 19.....,
and that death occurred on the date stated above, at 8.30 M.
The CAUSE OF DEATH* was as follows:
Some form of Kidney Trouble
..... (Duration) ..... Yrs. ..... mos. ..... ds.
Contributory (Secondary) .....
..... (Duration) ..... yrs. ..... mos. ..... ds.
(Signed) W. Wm H. McDill M. D.
19..... (Address) McCammon

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Grimo Ida	Oct 23 1920
20. UNDERTAKER	ADDRESS
Bannock Hdw	Pocatello Ida

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD
MARGIN RESERVED FOR BINDING

FORM V. S. No. 5-25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 38748

Registered No.

1. PLACE OF DEATH

County of Boner

Registration District No. 78

Primary Registration District No. 2155

City of ..... (If outside limits of city or village, give township.) ..... St.)

If death occurs away from usual residence, give facts called for under special information.

RECEIVED
JUL 12 1922
BUREAU OF VITAL STATISTICS

2. FULL NAME Edward Moen

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: male

4. COLOR OR RACE: white

5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.): Single

6. DATE OF BIRTH: July (Month) 4. (Day) 1920 (Year)

7. AGE: Yrs. 1 Mos. 19 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Boner County - Idaho

10. NAME OF FATHER: Anton M. Moen

11. BIRTHPLACE OF FATHER (State or Country): Norway

12. MAIDEN NAME OF MOTHER: Sigrida Torstad

13. BIRTHPLACE OF MOTHER (State or Country): Norway

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs. Sigrida Moen
(Address) Coeur d'Alene - Idaho

15. Filed July 2 1922 Viola Allen Deputy Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51088

MEDICAL CERTIFICATE OF DEATH

104

16. DATE OF DEATH: August (Month) 23. (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 29. 1920, to Aug. 23 1920 that I last saw h— alive on July 29 1920 and that death occurred on the date stated above, at 11:— P. M.
The CAUSE OF DEATH* was as follows:

Cholera Infantum

(Duration) Yrs. 1 mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Frank A Wing M. D.
4/6 1922 (Address) Rathdrum, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Westmond — DATE OF BURIAL: Aug 25 1920

20. UNDERTAKER: Rev. Torvik. — ADDRESS: Spokane

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

38807

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho. Registered No. 3
Township Nez Perce Reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Tema McCormack

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Indian	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	4			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai,
(State or country) Idaho

PARENTS
10 NAME OF FATHER Joseph McCormack
11 BIRTHPLACE OF FATHER (city or town) Alpowa,
(State or country) Wn
12 MAIDEN NAME OF MOTHER Annie Grant,
13 BIRTHPLACE OF MOTHER (city or town) Lapwai,
(State or country) Idaho.

14 Informant David McFarland,
(Address) Lapwai, Idaho.

15 Filed 12-28-20, 19 Corbett Sawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-28-20 19

17 I HEREBY CERTIFY, That I attended deceased from
----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:

T. B.

---------- (duration) ---- yrs. ---- mos. ---- ds.
CONTRIBUTORY
(SECONDARY)
---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? ---- Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Corbett Sawyer Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	12-29-20 19
20 UNDERTAKER J.N.Wann, Lapwai, Idaho.	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

38808

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Clear ater Co., Nez Perce Reservation State Idaho Registered No. 1
Township ____ or Village ____ or
City ____ No. ____, ____ St., ____ Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Daniel Damion

(a) Residence. No. ____ St., ____ Ward. ____
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Male	Indian	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Delia White Damion

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	26	--	--	

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer) ____
(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai,
(State or country) Idaho

PARENTS
10 NAME OF FATHER Damion
11 BIRTHPLACE OF FATHER (city or town) Nez Perce
(State or country) Reservation, Idaho.
12 MAIDEN NAME OF MOTHER Annie Damion
13 BIRTHPLACE OF MOTHER (city or town) Nez Perce
(State or country) Reservation, Idaho.

14 Informant David McFarland
(Address) Lapwai, Idaho.

15 Filed 12-22-20 Corbett Lawyer REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12/21/20 19

17 I HEREBY CERTIFY, That I attended deceased from ____, 19____, to ____, 19____,
that I last saw h____ alive on ____, 19____,
and that death occurred, on the date stated above, at ____m.
The CAUSE OF DEATH* was as follows:

accidentally shot while hunting.

____ (duration) ____ yrs. ____ mos. ____ ds.
CONTRIBUTORY (SECONDARY) ____
____ (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____
Did an operation precede death? ____ Date of ____
Was there an autopsy? ____
What test confirmed diagnosis? ____

(Signed) Corbett Lawyer Clerk, M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetary	12/22/20 19
20 UNDERTAKER	ADDRESS
W. E. Stoddard,	Gifford, Idaho.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 d
V. S. No. 98

38809

STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

1 PLACE OF DEATH
County Nez Perce State Idaho Registered No. 2
Township Nez Perce Reservation or Village or
City No. St., Ward
(If death occurred in a hospital or institution, give its NAME instead of street and number)

2 FULL NAME Martha Samuels Compo

(a) Residence. No. St., Ward.
(Usual place of abode) (If nonresident give city or town and State)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word)
Female	Indian	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ---- hrs. or ---- min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Invalid
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Lapwai,
(State or country) Idaho.

PARENTS
10 NAME OF FATHER Timothy Samuels
11 BIRTHPLACE OF FATHER (city or town) Nez Perce
(State or country) Reservation, Idaho.
12 MAIDEN NAME OF MOTHER Cecelia Pelotsonmy
13 BIRTHPLACE OF MOTHER (city or town) Kamiah,
(State or country) (Res) Idaho.

14 Informant Jackson Sundown
(Address) Culdesac Idaho

15 Filed 12-23-20, 19 Corbett Lawyer
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 12-23-20 19

17 I HEREBY CERTIFY, That I attended deceased from
----------, 19----, to ----------, 19----,
that I last saw h---- alive on ----------, 19----,
and that death occurred, on the date stated above, at ----------m.
The CAUSE OF DEATH* was as follows:

T. B.

---------- (duration) ---- yrs. ---- mos. ---- ds.
CONTRIBUTORY
(SECONDARY)
---------- (duration) ---- yrs. ---- mos. ---- ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Corbett Lawyer Clerk., M. D.
, 19 (Address) Lapwai, Idaho.

* State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Indian cemetery	12-24-20
20 UNDERTAKER J.N. Wann, Lapwai, Idaho.	ADDRESS

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8—209 4
V. S. No. 98

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

1. PLACE OF DEATH.

Registration District No. 98

County of Jefferson

Primary Registration District No. 2176

File No. 40016

City of Rigby (No. ....., ... St.)

Registered No. 64

If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Ardath Evans Jenkins

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.)
Female	White	Single

6. DATE OF BIRTH

August 10th 1918
(Month) (Day) (Year)

7. AGE

1 yrs. 6 mos. 9 ds.

IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION

(a) Trade, profession or particular kind of work ..... Baby

(b) General nature of industry business, or dstablishment in which employed (or employer) .....

9. BIRTHPLACE (State or Country) Rigby Idaho

10. NAME OF FATHER Daniel Jenkins

11. BIRTHPLACE OF FATHER (State or Country) Salt Lake Co. Utah

12. MAIDEN NAME OF MOTHER Florence Buck

13. BIRTHPLACE OF MOTHER (State or Country)

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Daniel Jenkins

(Address) Rigby Idaho

15.

Filed Nov 10 1922 Ray H Fisher
Local Registrar

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH February 19 1920
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from January 31st 1920, to January 17th 1920 that I last saw her alive on January 17th 1920, and that death occurred on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Influenza

(Duration) ..... yrs. ..... mos. 6 ds.

Contributory (Secondary) Broncho-pneumonia

(Duration) ..... yrs. ..... mos. 11 ds.

(Signed) George D Thompson M. D.

Feb 19th 1920 (Address) Rigby Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death .....yrs.....mos.....days. In the State .....yrs.....mos.....days.

Where was disease contracted if not at place of death? .....

Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Front Cemetery	Feb 20 1920

20. UNDERTAKER	ADDRESS
Joyce Ellison	Rigby Idaho

SYMS - YORK CO., PTRS. & BDRS. 19760

FORM V. S. No. 5-25 M. 1-16-13

CERTIFICATE OF DEATH.

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 42945

Registered No. .....

1. PLACE OF DEATH. Registration District No. 45

County of Kootenai Primary Registration District No. .....

City of Spirit Lake, Ida. (If outside limits, give township.) ..... St.)

RECEIVED AUG 22 1923 BUREAU OF VITAL STATISTICS

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME John A Anderson

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: M

4. COLOR OR RACE: W

5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): Married

6. DATE OF BIRTH. Feb (Month) 14 (Day) 1889 (Year)

7. AGE: 31 Yrs. 10 Mos. 9 ds. IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Lumber Contractor
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country): Sweden

10. NAME OF FATHER: A. J Anderson

11. BIRTHPLACE OF FATHER (State or Country): Sweden

12. MAIDEN NAME OF MOTHER: —

13. BIRTHPLACE OF MOTHER (State or Country): Sweden

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.
(Informant) Mrs Nellie Anderson
(Address) Spirit Lake Ida

15. Filed 1/15 1924 Geo Kinnick Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: June (Month) 5 (Day) 1920 (Year) 34

17. I HEREBY CERTIFY, That I attended deceased from ..... 191..., to ..... 191...,
that I last saw him alive on March 191...,
and that death occured on the date stated above, at H M.
The CAUSE OF DEATH* was as follows:
Epitheliomia of the tongue

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Earl D Connelly M. D.

19..... (Address) Spirit Lake Ida

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death.....yrs.....mos.....days In the State.....yrs.....mos.....days
Where was disease contracted if not at place of death?.....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL [redacted] DATE OF BURIAL Jan 11 1920

20. UNDERTAKER: A W Gibson Rathdrum Ida ADDRESS

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

MARGIN RESERVED FOR BINDING

SVMS - YORK CO., PTRS. & BDRS. 24854

Form V. S. No. 5 20M.1-16-12

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED JAN 1 1915 BUREAU OF VITAL STATISTICS

Registration District No. 41
Primary Registration District No. 2116

File No. 5-1914
Registered No. 51914A

1. PLACE OF DEATH.
County of Lemhi
City of Salmon
(No. ; St.)
If death occurs away from usual residence, give facts called for under special information.

If death occured in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME William John Browning

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX: m
4. COLOR OR RACE: white
5. SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word.): single

6. DATE OF BIRTH: May (Month) 1889 (Day) 1889 (Year)

7. AGE: 27 yrs. mos. ds.
IF LESS than 1 day how many ..... hrs. or ..... mins.?

8. OCCUPATION
(a) Trade, profession or particular kind of work:
(b) General nature of industry business, or dstablishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Russell Co Va

10. NAME OF FATHER: W. J. Browning

11. BIRTHPLACE OF FATHER (State or Country): Russell Co Va

12. MAIDEN NAME OF MOTHER: Mallie Rowden.

13. BIRTHPLACE OF MOTHER (State or Country): Pulaski Co Va

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) James S. Browning
(Address) Pocahontas Virginia

15.
Filed ..... 191 .....
Clio Bellamy
Local Registrar

SYMS - YORK CO., PTRS. & BDRS. 19760

MEDICAL CERTIFICATE OF DEATH.

16. DATE OF DEATH
August (Month) 22 (Day) 1914 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 14 1914, to Aug. 22 1914,
that I last saw h in alive on Aug. 22 1914,
and that death occurred on the date stated above, at 4 45 M.

The CAUSE OF DEATH* was as follows:
Plumbism
about 3 months
(Duration) yrs. mos. ds.
Contributory (Secondary)
(Duration) yrs. mos. ds.

(Signed) Chas F Hammer M. D.
Aug 22 1914. (Address) Salmon Idaho

*State the DISEASE CAUSING DEATH; or in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs ..... mos ..... days. In the State ..... yrs ..... mos ..... days.
Where was disease contracted if not at place of death?
Former or usual residence

19. PLACE OF BURIAL OR REMOVAL: Salmon cemetery
DATE OF BURIAL: Aug 24 1914

20. UNDERTAKER: Wm C Taebler
ADDRESS: Salmon Ida

Copy of original certificate

RECEIVED OCT 30 1926

STATE OF IDAHO 55724
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

DO NOT WRITE IN THIS SPACE
State File No. 55724

CERTIFICATE OF DEATH

PLACE OF DEATH

County of Cassia Registration District No.

City of Albion Primary Registration District No.

(No.) Local Registrar's No.

(If death occurred in a hospital or institution, give its name instead instead of street and number.)

2. FULL NAME ORVILLE J. SNODGRASS

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Nov. 16, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Rancher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Albion, Idaho.

PARENTS

10 NAME OF FATHER James Wilson Snodgrass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Illinois

12 MAIDEN NAME OF MOTHER Martha L. Pierson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Willard, Utah

14 Informant Mrs. Ida Snodgrass

(Address) Albion, Idaho

15 Filed Oct 30, 1926 David Burrell Registrar
State

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH April (Month) 25 (Day) 1920 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 2" 1919, to 19..., that I last saw h... alive on 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Sarcoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of

Was there an autopsy? I do not know

What test confirmed diagnosis? Laboratory

(Signed) [illegible], M. D.

Oct 26, 1926 (Address) Box 6, Rupert, Idaho

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19 Place of Burial, Cremation, or Removal	Date of Burial
Albion, Ida.	Apr. 29 1920
20. Undertaker	Address
L. B. GALLOGLY	BURLEY, IDA.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

RECEIVED FEB 1 1927

1. PLACE OF DEATH — Registration District No. .....
County of Washington — Primary Registration District No. .....
City of Cambridge — (No. ....., ... St.)
File No. 56450
Registered No. .....

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Samuel E Miller

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH — July (Month) 5 (Day) 1849 (Year)

7. AGE — 70 Yrs. 7 Mos. 4 ds. — IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business or establishment in which employed (or employer): .....

9. BIRTHPLACE (State or Country) Ill

10. NAME OF FATHER Morton Miller

11. BIRTHPLACE OF FATHER (State or Country) Ill Ind

12. MAIDEN NAME OF MOTHER .....

13. BIRTHPLACE OF MOTHER (State or Country) .....

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs Ella J Miller
(Address) Cambridge Ida

15. Filed 1-27 1927 — Local Registrar

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MEDICAL CERTIFICATE OF DEATH 10

16. DATE OF DEATH — Feb (Month) 9 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Jan. 24 1920, to Feb. 2 1920
that I last saw h[illegible] alive on Feb. 2 1920,
and that death occurred on the date stated above, at 6 P.M.
The CAUSE OF DEATH* was as follows:
Influenza & coma
also senility.

..... (Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary) .....

..... (Duration) ..... yrs. ..... mos. ..... ds.

(Signed) F. E. Schmitt M. D.
2/9-1920 (Address) Fruitland Ida

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days
Where was disease contracted if not at place of death? .....
Former or usual residence .....

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cambridge	2-11 1920
20. UNDERTAKER	ADDRESS
J A Anderson	Cambridge

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

FORM V. S. No. 5-A—25 M. 10-

RECEIVED FEB 1

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics
File No. 56451

1. PLACE OF DEATH

Registration District No.

County of

Primary Registration District No.

City of (No. , St.)

Registered No.

If death occurs away from usual residence, give facts called for under special information.

2. FULL NAME Charles Earnest Schmidt

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
Male	White	Married

6. DATE OF BIRTH: Oct. (Month) 22 (Day) 1879 (Year)

7. AGE: 41 Yrs. 4 Mos. 1 ds. IF LESS than 1 day how many hrs. or min.?

8. OCCUPATION
(a) Trade, profession or particular kind of work: Physician
(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Kansas

10. NAME OF FATHER: John Schmidt

11. BIRTHPLACE OF FATHER (State or Country): Germany

12. MAIDEN NAME OF MOTHER: Christina Bauer

13. BIRTHPLACE OF MOTHER (State or Country): Germany

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Dr F A Schmidt
(Address) Emmett Ida Ho

15. Filed 2-27 1930 W. H. Evans Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: Feb (Month) 23 (Day) 1930 (Year)

17. I HEREBY CERTIFY, That I attended deceased from 2-23-1930, to 2-23-1930 that I last saw him alive on 2-23-1930, and that death occurred on the date stated above, at 11:15 M.

The CAUSE OF DEATH* was as follows:

Pneumonia

(Duration) Yrs. mos. 2 ds.

Contributory (Secondary) Influenza.

(Duration) yrs. mos. 4 ds.

(Signed) W. H. Livingston M. D.

1930 (Address) Cambridge, Ida.

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death yrs. mos. days. In the State yrs. mos. days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Cambridge—Idaho	2-25-1930

20. UNDERTAKER J. A. Hudson ADDRESS Cambridge—Ida.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

68971

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 68971

Registration District No. .....
Primary Registration District No. .....
Local Registrar's No. .....

PLACE OF DEATH
County of Jefferson
City of Rigby
(No. .....)
(If death occurred in a hospital or institution, give its name instead of street and number.)

176

2. FULL NAME Wm W Henry Baumbrick

(a) Residence. No. ..... St. .....
(Usual place of abode)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Male	White	Divorced

5a. If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6. DATE OF BIRTH (month, day and year) April 19-1889

7. AGE	Years	Months	Days	If LESS than 1 day,
	31	6	3	..... hrs. or ..... min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Cement Worker
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9. BIRTHPLACE (city or town) (State or country) Georgetown Cal

PARENTS

10. NAME OF FATHER Wm Baumbrick
11. BIRTHPLACE OF FATHER (city or town) (State or Country) W. Va
12. MAIDEN NAME OF MOTHER Isabelle Swan
13. BIRTHPLACE OF MOTHER (city or town) (State or Country) Ireland

14. Informant .....
(Address) .....

15. Filed Jan 24 1930 W H Rhodes Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH Oct. (Month) 22d (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from ....., 19..... to ....., 19.....
that I last saw h..... alive on ....., 19.....
and that death occurred, on the date stated above, at .....m.
The CAUSE OF DEATH* was as follows:
Broken Neck
Auto Accident
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18. Where was disease contracted if not at place of death? .....
Did an operation precede death? ..... Date of .....
Was there an autopsy? .....
What test confirmed diagnosis? .....
(Signed) H. A. Andersen, M. D.
....., 19..... (Address) Rigby Ida

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. Place of Burial, Cremation, or Removal	Date of Burial
St Johns Cemetery	Oct 26 1920
20. Undertaker	Address
Sorensen & Sidenfaden	Boise

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY, PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

FORM V. S. No. 5-A—25 M. 1-19.

CERTIFICATE OF DEATH

State of Idaho
BOARD OF HEALTH
Bureau of Vital Statistics

File No. 15366

Registered No. 24

1. PLACE OF DEATH

County of Lincoln

City of Shoshone

If death occurs away from usual residence, give facts called for under special information.

Registration District No. 16

Primary Registration District No. 2016

(No. ..... St.)

If death occurred in a hospital, institution or camp, give its NAME instead of street and number.

2. FULL NAME Manuel Ineas

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word.)
male	white	Widowed

6. DATE OF BIRTH: April (Month) 12 (Day) 1847 (Year)

7. AGE: 73 Yrs. 3 Mos. 4 ds.

IF LESS than 1 day how many ..... hrs. or ..... min.?

8. OCCUPATION

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business or establishment in which employed (or employer):

9. BIRTHPLACE (State or Country): Azores Islands

10. NAME OF FATHER: Manuel Ineas

11. BIRTHPLACE OF FATHER (State or Country): Azores Islands

12. MAIDEN NAME OF MOTHER: Mary Ivafund

13. BIRTHPLACE OF MOTHER (State or Country): Azores Islands

14. THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Joe Ineas

(Address)

15. Filed July 26 1920

Local Registrar

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH: July (Month) 25 (Day) 1920 (Year)

17. I HEREBY CERTIFY, That I attended deceased from July 22 1920, to July 22 1920, that I last saw him alive on July 22 1920, and that death occurred on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Putteisis

(Duration) ..... Yrs. ..... mos. ..... ds.

Contributory (Secondary)

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) C. P. Jones M. D.

19 ..... (Address) Shoshone, Idaho

*State the Disease Causing Death; or in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal or Homicidal.

18. LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... days. In the State ..... yrs. ..... mos. ..... days

Where was disease contracted if not at place of death?

Former or usual residence

19. PLACE OF BURIAL OR REMOVAL	DATE OF BURIAL
Shoshone, Idaho	July 26 1920
20. UNDERTAKER	**ADDRESS**
O. J. Brennan	Shoshone, Ida.

MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK — THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

SYMS-YORK CO., PRINTERS & BINDERS, BOISE 51087

STATE OF IDAHO

DEPARTMENT OF PUBLIC WELFARE

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

RECEIVED JAN [illegible] 1937

DO NOT WRITE IN THIS SPACE

State File No. 77406

77406

90

PLACE OF DEATH

County of Bannock

City of Grace

Registration District No. 274

Primary Registration District No. 28

Local Registrar's No. .....

(No. .....)

(If death occurred in a hospital or institution, give its name instead of street and number.)

2. **FULL NAME** Arthur E. Sabin

(a) Residence. No. Near Grace, Idaho. St. .....

(Usual place of abode.) (If nonresident give city or town and State.)

Length of residence in city or town where death occured. yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word.)
M.	W.	single

5a. If married, widowed, or divorced
HUSBAND of
~~(or)~~ WIFE of

6. DATE OF BIRTH (month, day and year) 3/20/87

7. AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.

8. OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Farm Laborer
(c) Name of employer Jacob Egley

9. BIRTHPLACE (city or town) .....
(State or country) Spring Creek, Idaho.

PARENTS

10. NAME OF FATHER Eroi B. Sabin

11. BIRTHPLACE OF FATHER (city or town) .....
(State or Country) Salt Lake City, Ut.

12. MAIDEN NAME OF MOTHER Sarah Walker

13. BIRTHPLACE OF MOTHER (city or town) .....
(State or County) Brigham City, Ut

14. Informant Jacob Egley
(Address) Grace, Idaho.

15. Filed 5/23/20, 19..... Ellis Lackley
Registrar.

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH ~~1/3/20~~ 5/22/20
(Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from 1/5/20, 19....., to 5/22/20, 19.....
that I last saw him alive on 5/20/20, 19.....
and that death occurred, on the date stated above, at .....m.

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.
The CAUSE OF DEATH* was as follows:
Organic Heart Disease,
Mitral Insuf. with Stenosis.
about one
(duration) .....yrs. .....mos. .....ds.
CONTRIBUTORY (Secondary) Passed in battle during war.
about one year or more
(duration)* .....yrs. .....mos. .....ds.

18. Where was disease contracted if not at place of death? In France
Did an operation precede death? 0 Date of .....
Was there an autopsy? 0
What test confirmed diagnosis? Physical Examination

(Signed) Ellis Lackley M. D.
5/23/20, 19..... (Address) Soda Springs

19. Place of Burial, Cremation, or Removal	Date of Burial
Grace, Idaho,	5/[illegible] 19

20. Undertaker John Roghaar Address grace

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD.
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified.
Exact statement of OCCUPATION is very important. See instructions on back.
MARGIN RESERVED FOR BINDING

RECEIVED MAR 7 1932

STATE OF IDAHO
DEPARTMENT OF PUBLIC WELFARE
BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

DO NOT WRITE IN THIS SPACE
State File No. 78208

PLACE OF DEATH
County of Bear Lake
City of Paris

Registration District No. 53
Primary Registration District No.
Local Registrar's No. 172

(No.)
(If death occurred in a hospital or institution, give its name instead of street and number.)

2. FULL NAME Pauline Schoch Keller

1 in 9

(a) Residence. No. St.
(Usual place of abode) (If nonresident give city or town and state)
Length of residence in city or town where death occurred. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. Single, Married, Widowed, or Divorced (write the word)
Female	white	Widow

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Keller

6. DATE OF BIRTH (month, day, and year) Oct. 10th 1853

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67	3	7	

OCCUPATION
8. Trade, profession, or particular kind of work done, as spinner, sawyer, bookkeeper, etc. Housewife
9. Industry or business in which work was done, as silk mill, saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year)
11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Strubing
(State or country) Kt. Zurich Switzerland

FATHER
13. NAME Schoch
14. BIRTHPLACE (city or town) Strubing
(State or country) Kt. Zurich Switzerland

MOTHER
15. MAIDEN NAME Not Known
16. BIRTHPLACE (city or town) Not Known
(State or country)

17. INFORMENT Mrs. Louise Studer
(Address) Paris Idaho

18. BURIAL, CREMATION, OR REMOVAL
Place Paris Idaho Date Jan 20th, 1932

19. UNDERTAKER
(Address)

20. FILED May 6th, 1931 Dr. C. O. Moore
Registrar.
Rev. Mrs. S. Hess

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (month, day, and year) Jan 17 - 1932

22. I HEREBY CERTIFY, That I attended deceased from Dec. 18th, 1931, to Jan 17th, 1932

I last saw her alive on Jan 17th, 1932: death is said to have occurred on the date stated above, at 8:30a m.

The principal cause of death and related causes of importance were as follows:

	Date of onset
Pneumonia-Bronchial	

Other contributory causes of importance:

Name of operation Date of
What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (violence) fill in also the following:
Accident, suicide, or homicide? Date of injury , 193
Where did injury occur?
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury
Nature of injury

24. Was disease or injury in any way related to occupation of deceased?
If so, specify
(Signed) C. O. Moore, M. D.
(Address) Paris Idaho

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instruction on back of certificate.

MARGIN RESERVED FOR BINDING

Informant, Funeral Director, Registrar and Medical Attendant, EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215). Address correspondence to State Bureau of Vital Statistics, Boise, Idaho.

United States
Department of Commerce
Bureau of the Census

Certificate Of Death

STATE OF IDAHO

State File No. 156475
Local Reg. No. 4
Reg. Dist. No. 142

1. **PLACE OF DEATH:**
   (a) County Shoshone
   (b) City or town Wardner
   (c) Street Address or R. F. D. No.
   (d) Death Occured Inside? X Outside? ....city or town
   (e) Died in a Home X Hospital.... Institution.... Other place....
   (f) Name Hosp. or Inst. — Stayed.....days
   (g) Lived in this county.....years 9 months .....days
   Note. For a person residing in THIS county LESS than 1 year, give FORMER residence under item 2.

2. **Usual Residence of Deceased:** (Always fill in these)
   (a) State Idaho (b) County Shoshone
   (c) City or town Kellogg
   (d) Street Address or R.F.D. No.
   (e) Deceased lived Inside? X Outside? ....city or town
   (f) Citizen of what country? U S
   (g) How long had deceased lived in Idaho? 9 months years
   (h) Former residence (city, state) Cornwall England

3. (a) **FULL NAME** Anna Nettle Sims

3. (b) If veteran, name war —
3. (c) Social Security No. —
4. Sex F
5. Color or race W
6. (a) Single, widowed, married, divorced Married
6. (b) Name of husband or wife Thomas
6. (c) Age of husband or wife if alive 31 years
7. Date of Birth (Month, Day, Year) March 10, 1890

8. AGE	Years	Months	Days	If less than 1 day
	30	2	14	hrs min.

9. Exact Occupation House wife — Did this work for .....yrs.
10. Industry or Business Home — Date last worked May 1920
11. Birthplace Cornwall - England (City or town) (State or foreign country)

Father
12. Name Matthew Nettle
13. Birthplace Cornwall, Eng. (City or town) (State or foreign country)

Mother
14. Maiden name Mc Ryan
15. Birthplace Mc Kerd (City or town) (State or foreign country)

16. Informant's **OWN** Signature E B Thygesen
and Address Kellogg Idaho

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof May 27 1920 (Month) (Day) (Year)
(c) Place: Kellogg Idaho

18. Funeral Director's **OWN** Signature E B Thygesen
and Address Kellogg Idaho

19. (a) 5/26/1920 (Date received and filed) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATE OF DEATH

20. **DATE OF DEATH** (Month, Day, Year) May 24 1920
at 3 o'clock PM.

21. **I HEREBY CERTIFY,** That I attended deceased from May 1st 1920, to May 24 1920
I last saw her alive on May 24th 1920, death is said to have occurred on the date and hour stated above.

Immediate Cause of Death: — Duration

Albuminuria following
Due to Child birth
Due to
Other conditions (Include pregnancy within 3 months of death)

Where was disease contracted?
Name of operation ..... Date.....
Major finding
Finding of autopsy

PHYISICIAN Underline the cause to which death should be charged statistically.

22. If death was due to **EXTERNAL CAUSES,** also fill in the following: Accident?..... Suicide?..... Homicide?.....
Occurred..... 19..... City, county, state where violence occurred
Place of Violence: Home.....Farm.....Industry.....
Public Place..... While at work?.....
Means of injury

23. Attendant's **OWN** Signature T. R. Mason M.D.
(M. D. or other)
and Address Kellogg Ida. Date 5/26 1948
(For additional space, use reverse side)

15

DELAYED CERTIFICATE

State of Idaho

CERTIFICATE OF DEATH

State File No. 156495

Local Reg. No. 123

ONLY A COPY OF THIS DOCUMENT, CERTIFIED BY THE STATE REGISTRAR, **WITH THE DEPT. OF HEALTH & WELFARE RAISED SEAL**, SHALL BE USED AS PRIMA FACIE EVIDENCE OF THIS DEATH UNDER **IDAHO CODE** 39-241(k) & 39-274

DECEDENT

TYPE OR PRINT IN PERMANENT BLACK INK DO NOT USE FELT TIP PEN

DECEDENT — NAME (First / Middle / Last)	SEX	DATE OF DEATH (Mo., Day, Yr.)
1. Sidney Hector Lloyd	2. Male	3. April 7, 1920 approx.

RACE - (White, Black, American Indian, Japanese, etc.)	AGE - Last Birthday (Yrs.)	UNDER 1 YEAR MOS. / DAYS	UNDER 1 DAY HOURS / MINS.	DATE OF BIRTH (Mo., Day, Yr.)	COUNTY OF DEATH
4. white	5a. 29	5b.	5c.	6. Sept. 2, 1890	7a. Cassia

CITY, TOWN OR LOCATION OF DEATH	HOSPITAL OR OTHER INSTITUTUION — Name (If not in either, give street and number)	IF HOSP. OR INST. Indicate DOA, OP/Emer. Rm., Inpatient (Specify)
7b. Savage Hollow NE of Almo	7c.	7d.

STATE OF BIRTH (If not in U.S.A., name country)	CITIZEN OF WHAT COUNTRY	MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	SURVIVING SPOUSE (If wife, give maiden name)	WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)
8. Montana	9. USA	10. Never Married	11.	12. yes

SOCIAL SECURITY NUMBER	USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	KIND OF BUSINESS OR INDUSTRY
13.	14a.	14b.

RESIDENCE STATE	COUNTY	CITY, TOWN OR LOCATION	STREET AND NUMBER	INSIDE CITY LIMITS (Yes or No)
15a. Idaho	15b. Cassia	15c. Almo	15d.	15e.

PARENTS

FATHER — NAME	BIRTHPLACE	MOTHER — MAIDEN NAME	BIRTHPLACE
16a.	16b.	17a.	17b.

INFORMANT — NAME	MAILING ADDRESS (STREET OR R.F.D. NO. / CITY OR TOWN / STATE / ZIP)
18a.	18b.

DISPOSITION

BURIAL, CUT-OF-STATE REMOVAL, CREMATION, ENTOMBMENT, OTHER (Specify)	DATE	CEMETERY OR CREMATORY — NAME	LOCATION (CITY OR TOWN / STATE)
19a. Research	19b. Unknown	19c. Pocatello Reg. Med. Ctr.	19d. Pocatello, ID 83201

MORTICIAN (Signature) / LICENSE NO.	NAME OF FACILITY	ADDRESS OF FACILITY (ZIP)
20a. ► Dr. Charles O. Garrison	20b. Pocatello Reg. Med. Ctr.	20c. Pocatello, Id 83201

CERTIFIER

IF DEATH WAS DUE TO OTHER THAN NATURAL CAUSES, THE CORONER MUST COMPLETE AND SIGN THE CERTIFICATE

To be Completed by ATTENDING PHYSICIAN Only

21a. I hereby certify that I attended the deceased from _____ to _____;

I last saw the deceased alive on _____. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.

(Signature and Title) ►

DATE SIGNED (Mo., Day, Yr.)	HOUR OF DEATH
21b.	21c.

To be Completed by CORONER Only

22a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated.

(Coroner's Signature) ► Paul B. Young

DATE SIGNED (Mo., Day, Yr.)	HOUR OF DEATH
22b. July 13, 1987	22c. unknown M

PRONOUNCED DEAD (Mo., Day, Yr.)	PRONOUNCED DEAD (Hour)
22d. ON July 17, 1985	22e. AT 11:30 A M

NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR CORONER) (Type or Print)

23. Paul B. Young, Coroner 413 W. 26th Burley, Idaho 83318

REGISTRAR	DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)
24a. (Signature) ► Mary C. Tucker	24b. July 15 1987

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

25. **PART I** Enter Only One Cause Per Line For (a), (b), (c)

		Interval between onset and death
IMMEDIATE CAUSE (a)	Hypothermia and Exposure	unknown
DUE TO, OR AS A CONSEQUENCE OF: (b)		
DUE TO, OR AS A CONSEQUENCE OF: (c)		

PART II OTHER SIGNIFICANT CONDITIONS — Conditions contributing to death but not related to cause given in PART I (a)

AUTOPSY (Yes or No) 26. yes

TO BE USED FOR EXTERNAL CAUSES ONLY

ACC. SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)	DATE OF INJURY (Mo., Day, Yr.)	HOUR OF INJURY	DESCRIBE HOW INJURY OCCURRED
27a. accident	27b. Apr 7, 1920	27c. unk M	27d. caught in snowstorm while hunting

INJURY AT WORK (Yes or No)	IF TRANSPORTATION ACCIDENT, Specify	PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	LOCATION STREET OR R.F.D. NO., CITY/TOWN OR COUNTY / STATE
27e. no	27f. ☐ Driver ☐ Passenger ☐ Pedestrian ☐ Other	27g. hillside	27h. NE of Almo Cassia Idaho

HWH-0128 revised 7-86

*At a minimum, complete items 1; 3; 7a, b, c, d; 20a, b, c; and 23 for the 24 Hour Report & Authorization For Final Disposition

VITAL STATISTICS COPY

No 16700

State of Idaho
Department of Health and Welfare
Vital Statistics Unit
Statehouse
Boise, Idaho 83720-9990

August 21, 1987

Attn: Greg Heitman

RECEIVED
Vital Statistics Unit AUG 24 1987

Re: Sidney Hector Lloyd

The skeletal remains of Sidney Hector Lloyd found in the Almo, Idaho area in July, 1985 are currently in the possession of Dr. Charles O. Garison. These remains will continue in Dr. Garison's possession to be used for research and teaching purposes.

Paul B. Young

Paul B. Young
Coroner, Cassia County